Proposed Ureteroscopy DECC

- One site model – based on following assumptions:
  - Site location to be agreed within reasonable travel distance of current consultants providing service
  - All consultants delivering Ureteroscopy procedures currently would feed into new model (13 – 15 people) resulting in each consultant undertaking full list in elective centre every 2-3 weeks approx.
  - Level of demand warrants ring fenced theatre – specific equipment requirements (image intensifier / laser)
  - All patients will be centrally pooled to ensure equity of access and consistent waiting times across the region. Consultants to work on pooled lists with ability to request certain cases (complex / recurring patients) are added to their own list

Proposed Ureteroscopy DECC

- Elective centre should operate 8am – 9pm to ensure last procedure (finishing 5.30pm) can be appropriately recovered and discharged home before closing unit – with this arrangement a stand alone unit will be suitable
- Estimated 80% of current elective cases could safely move to standalone elective centre with approx. 20% cases remaining in acute inpatient setting due to complexity / co-morbidities.
- Dedicated urology nursing staffing would be beneficial although we know with current nursing workforce pressure this may not be possible)
- Pre-assessment could be carried out at Trust own site by staff working in DECC or centrally at DECC –this is to be discussed. There would be a requirement for patients be cleared by anaesthetists and nursing staff familiar with working within DECC

ESWL Activity Drill Down (HSCB)

	15/16	16/17	17/18	18/19
Elective Admissions	14	8	7	5
Elective Day Case	1001	878	830	887
Non Elective Activity	5	4	10	

ESWL

- Expected demand = 951 procedures annually
- Maximum 1840 procedures could be undertaken to address demand and tackle waiting list
- Modelling scenarios:

Days (session/day)	weeks	Cases per session	
5 (2)	46	4	1840
5 (2)	46	3	1380
5 (2)	46	2	920

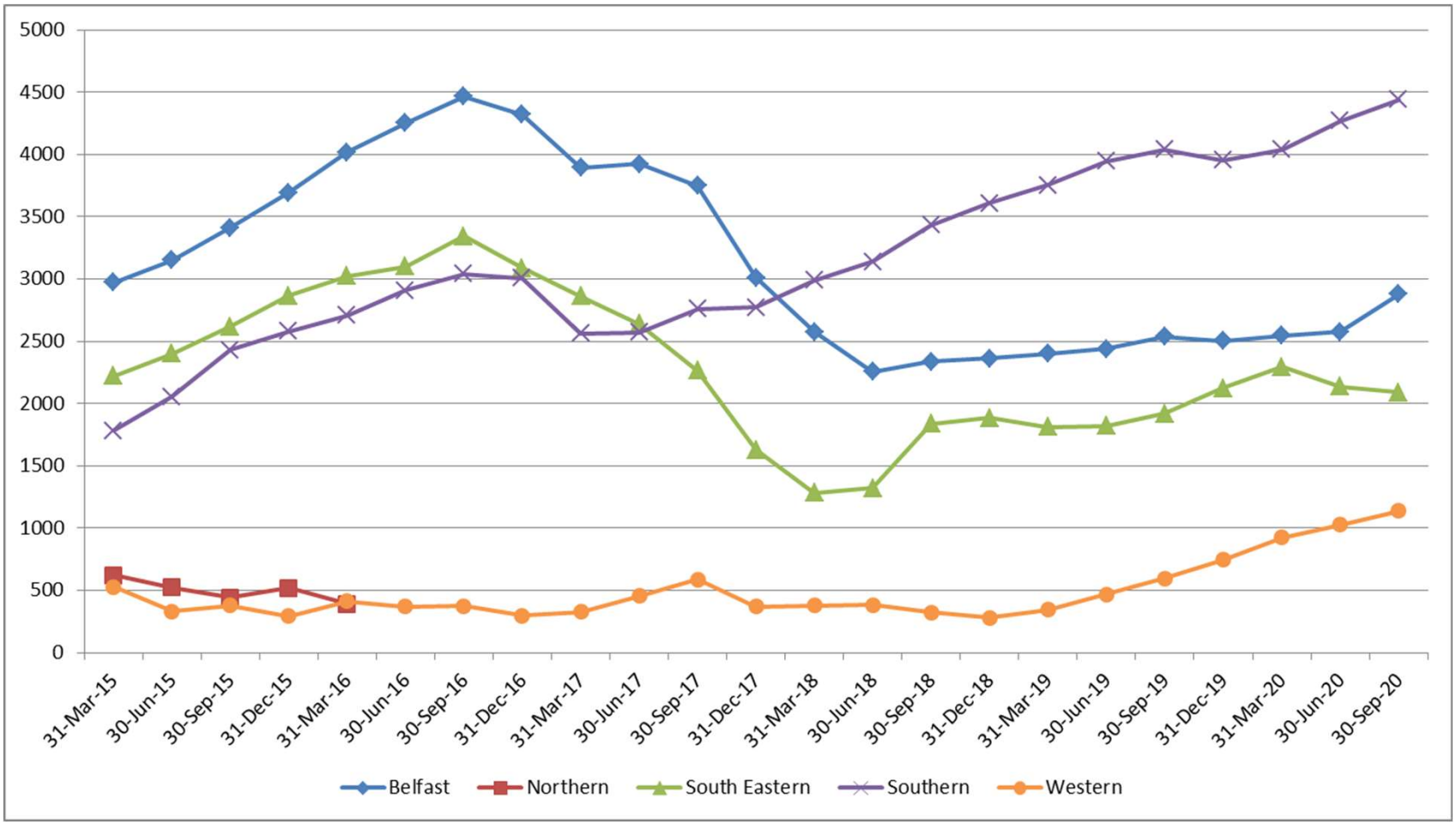
**46 weeks based on annual leave and maintenance down time for machine*

Proposed ESWL DECC

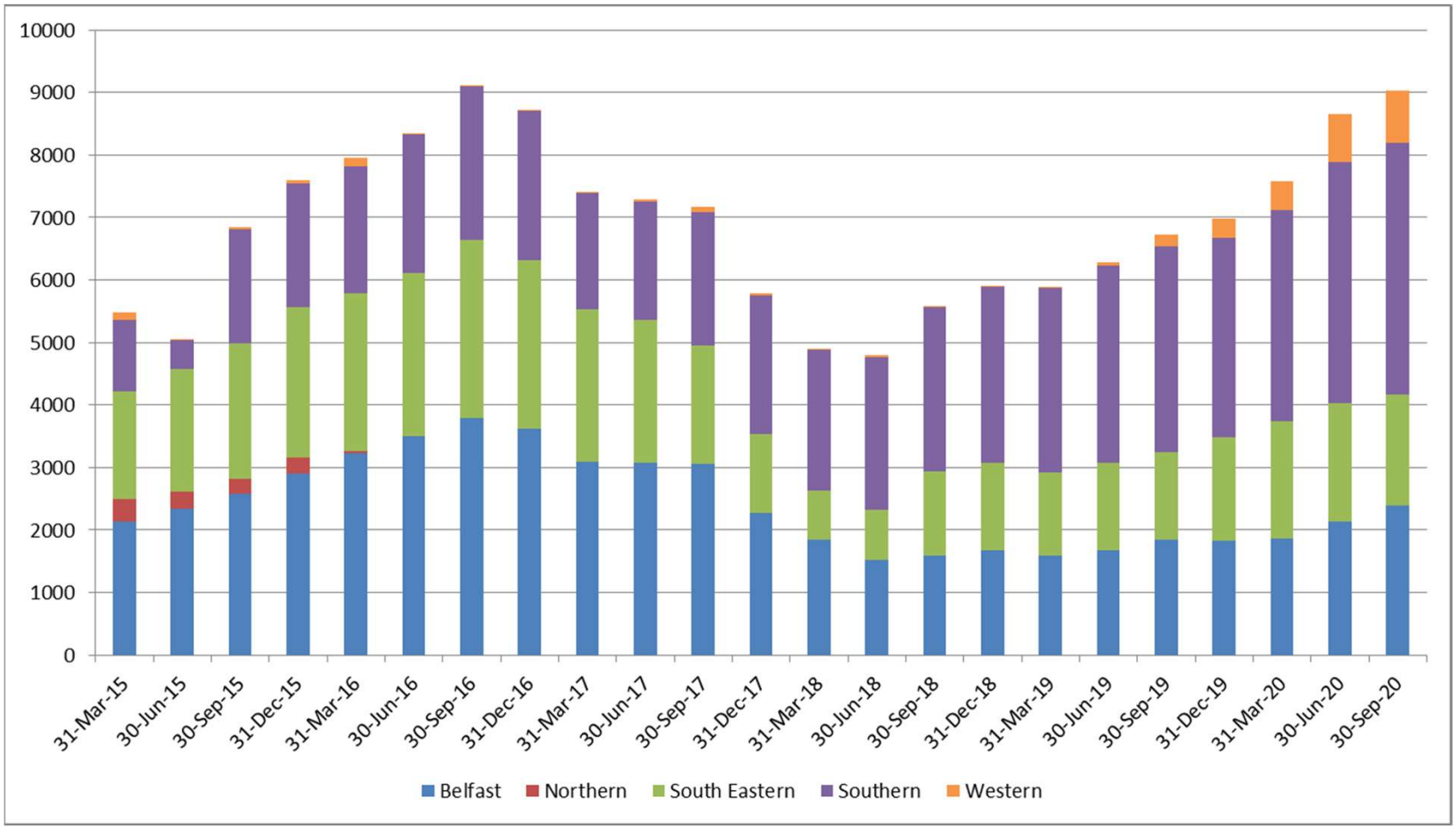
- One site model – based on following assumptions:
  - One site can manage expected demand along with capacity to deliver NICE guidelines of 48hr treatment for emergency cases
  - Maximise CAH fixed lithotripter
  - Infrastructure and staffing resources required to deliver model
  - Pooled lists and patients

Urology
Current Service Pressures
Oct 2020

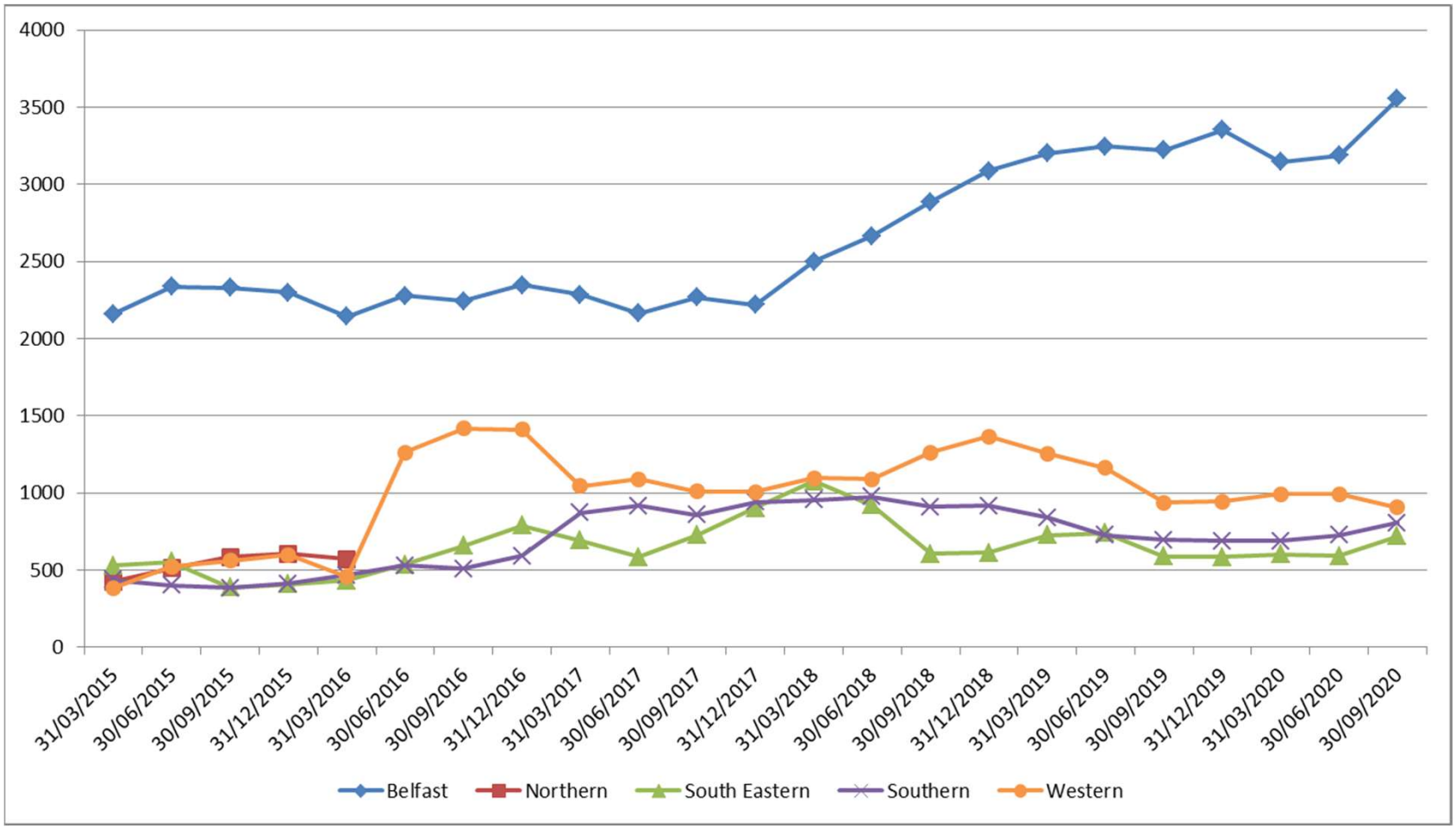
Total Outpatients Waiters By Trust



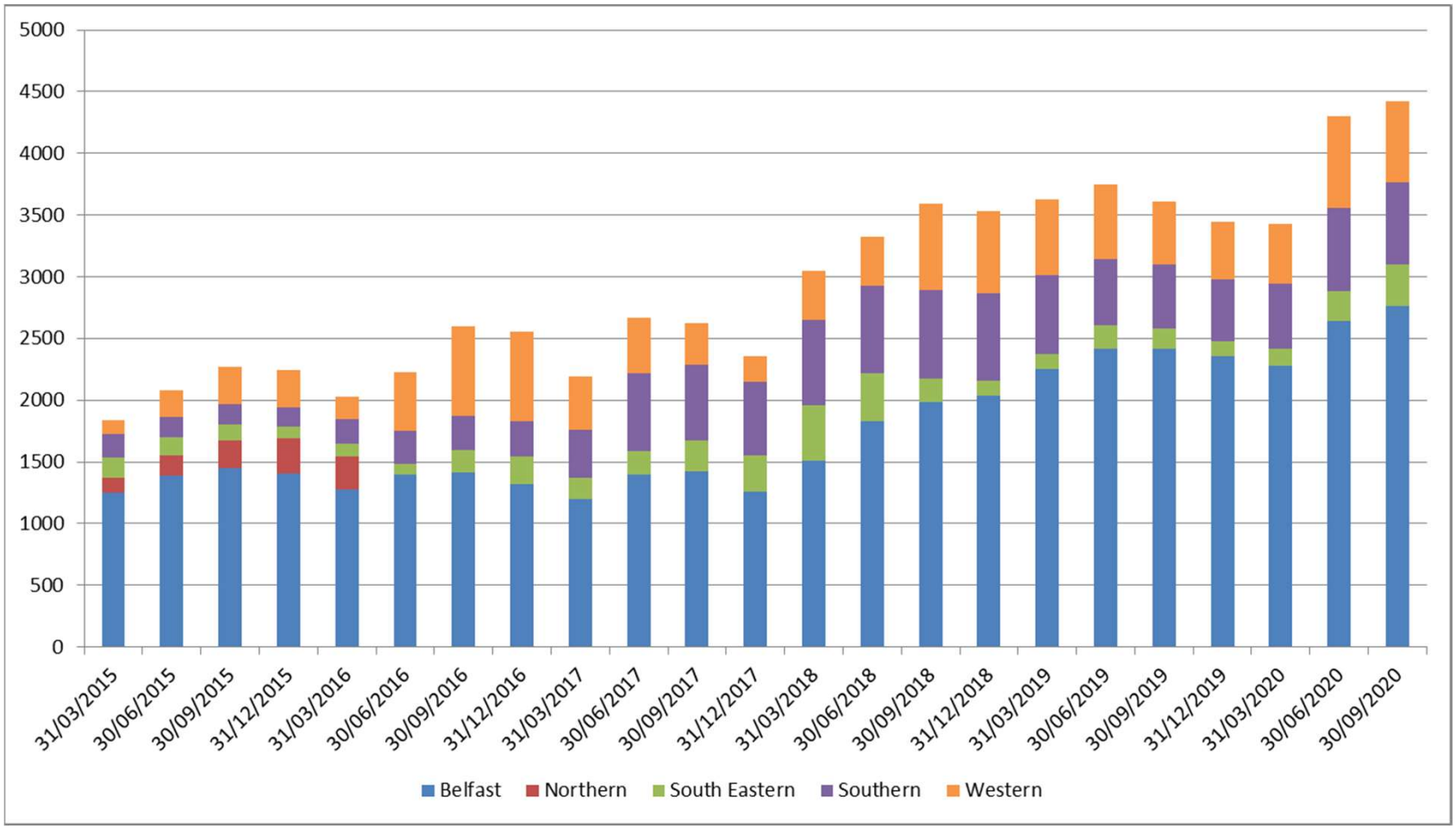
Over 9 week OP Waiters By Trust



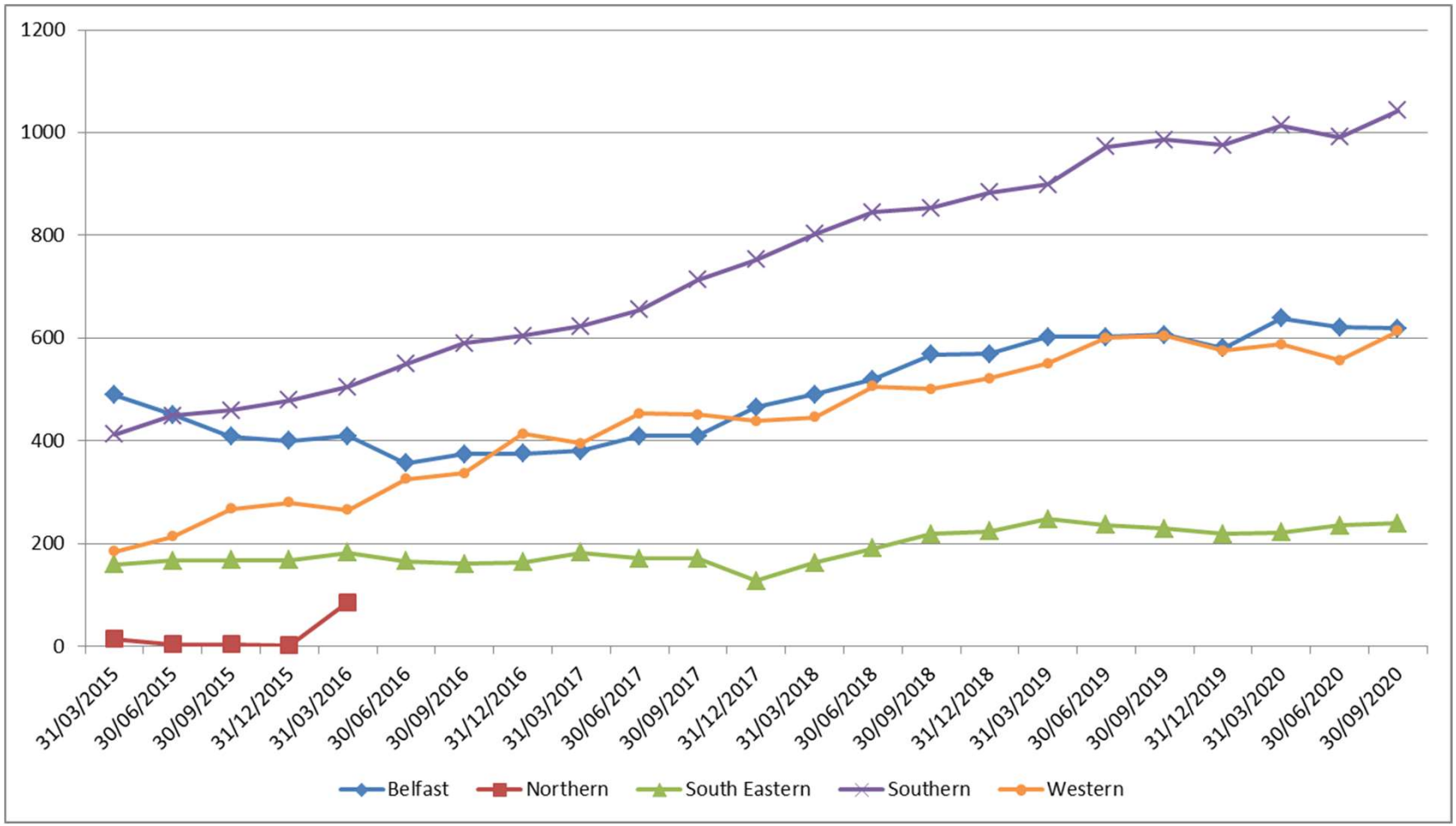
Total Day Case Waits By Trust



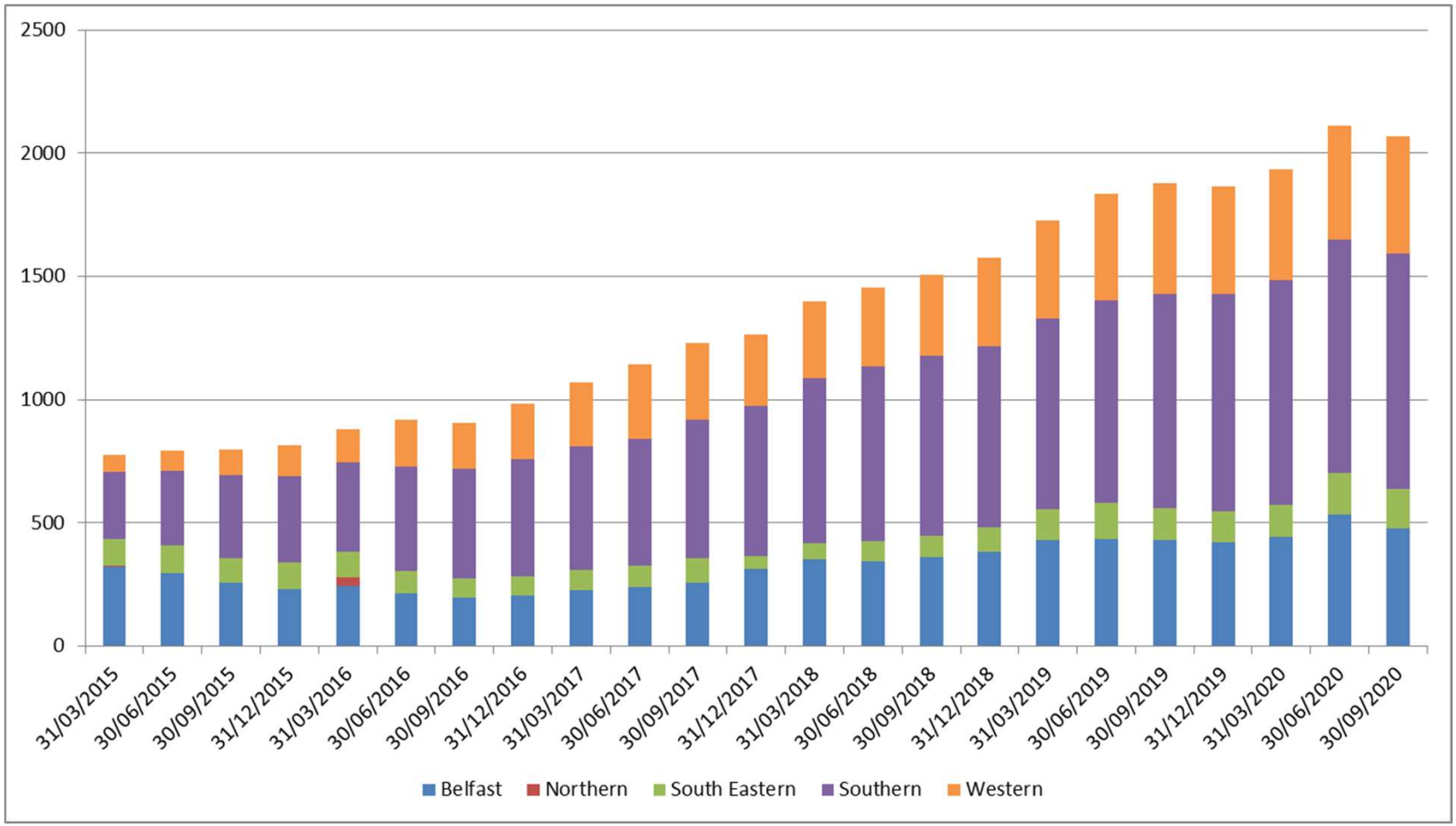
Over 13 Week DC Waiters By Trust



Total Inpatient Waits By Trust



Over 13 Week IP Waiters By Trust



Urology Cancer
62 Day Waiters @2 September

Trust	Belfast	SET	Southern	Western	TOTAL
62 day +	284	57	128	9	478

Other Challenges

- Lack of in-house operating capacity
- Reduced IS access
- Outlet for urgent benign cases
- Staff vacancies
- Staff skill mix
- Backlog…impact of time delays

Opportunities?

Urology IPDC Waiting list @ 30th September 2020

BADS	BADS Description	Total Waiting	Procedure	Zero night stay	One night stay	Two night stay
M45	Diagnostic endoscopic examination of bladder (including any biopsy)	1752	90	5	5	
N17	Vasectomy	1110	80	20		
N30	Operations on foreskin – circumcision, division of adhesions	956		99	1	
M65.3	Endoscopic resection of prostate (TUR)	676		15	45	40
M65.1	Endoscopic resection of prostate (TUR)	271		15	45	40
N11	Correction of hydrocele	266		99	1	
N15	Excision of epididymal lesion	165		99	1	
M44.1	Endoscopic extraction of calculus of bladder	136		60	40	
M27	Other endoscopic procedures on ureter	89		90	10	
M02.5	Laparoscopic nephrectomy	87		5	70	25
N28.4	Frenuloplasty of penis	82		99	1	
M42	Endoscopic resection/destruction of lesion of bladder	78		60	35	5
M28	Other endoscopic procedures on ureter	52		90	10	
M66.2	Endoscopic incision of outlet of male bladder	42		50	50	

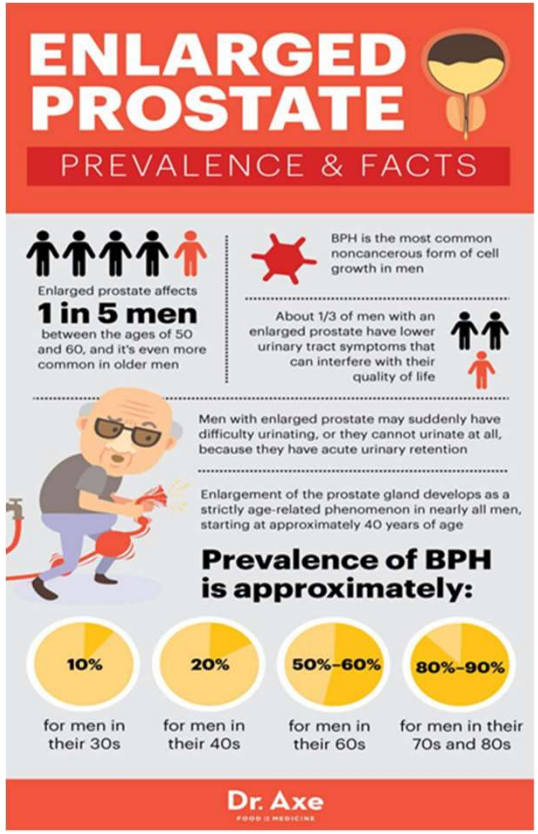
Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

BPH surgery as a day case (DECC)

Ajay Pahuja

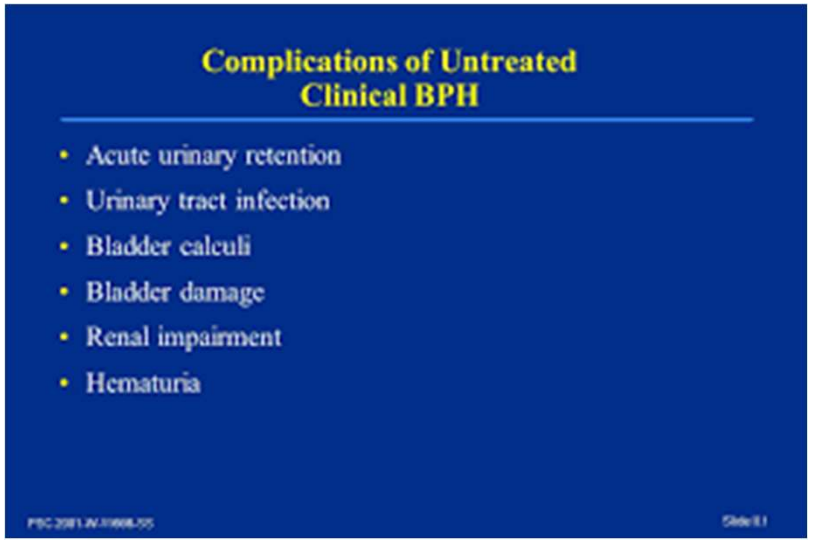
Consultant Urologist

BHSCT



90% of men between 45 and 80 years of age will suffer from some type of lower urinary tract symptoms (LUTS).

By age 60, half of all men have BPH symptoms.



Urology units across NI
All units (M or B TURP)

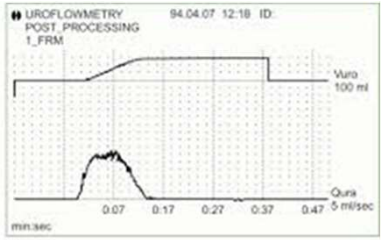
- WSCHT – TURP, ?PUL
- SHSCT – TURP and GLLP (180W)
- BHSCT – TURP, GLLP, Urolift (PUL), (Rezum – business case submitted) and PAE on a case by case basis
- SET – TURP, Plans to start HOLEP?

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

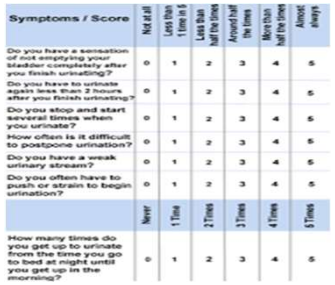
BCH – LUTS clinic

- Nurse led LUTS clinic + speciality doctor (overseen by consultant)
- W/W or Medical therapy + Tel clinic 12/52 – discharge if happy
- Urodynamics in select cases / complex LUTS
- Surgical options discussed = patient then gets TRUS volume
- BAUS leaflets on various options
- Waiting list (TURP/GLLP/PUL)

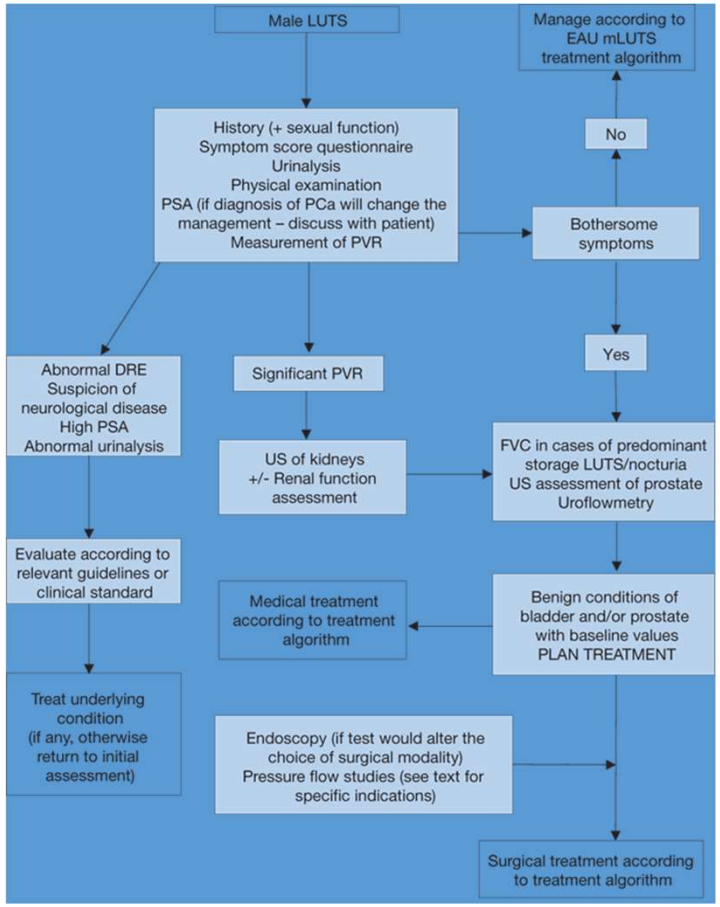
A



B



Symptoms / Score	Not at all	Less than 1 time in 5	Less than half the times	Around half the times	More than half the times	Almost always
Do you have a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5
Do you have to urinate again less than 2 hours after you finish urinating?	0	1	2	3	4	5
Do you stop and start several times when you urinate?	0	1	2	3	4	5
How often is it difficult to postpone urination?	0	1	2	3	4	5
Do you have a weak urinary stream?	0	1	2	3	4	5
Do you often have to push or strain to begin urination?	0	1	2	3	4	5
	Never	1 Time	2 Times	3 Times	4 Times	5 Times
How many times do you get up to urinate from the time you go to bed at night until you get up in the morning?	0	1	2	3	4	5



Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Other factors that need to be taken into consideration

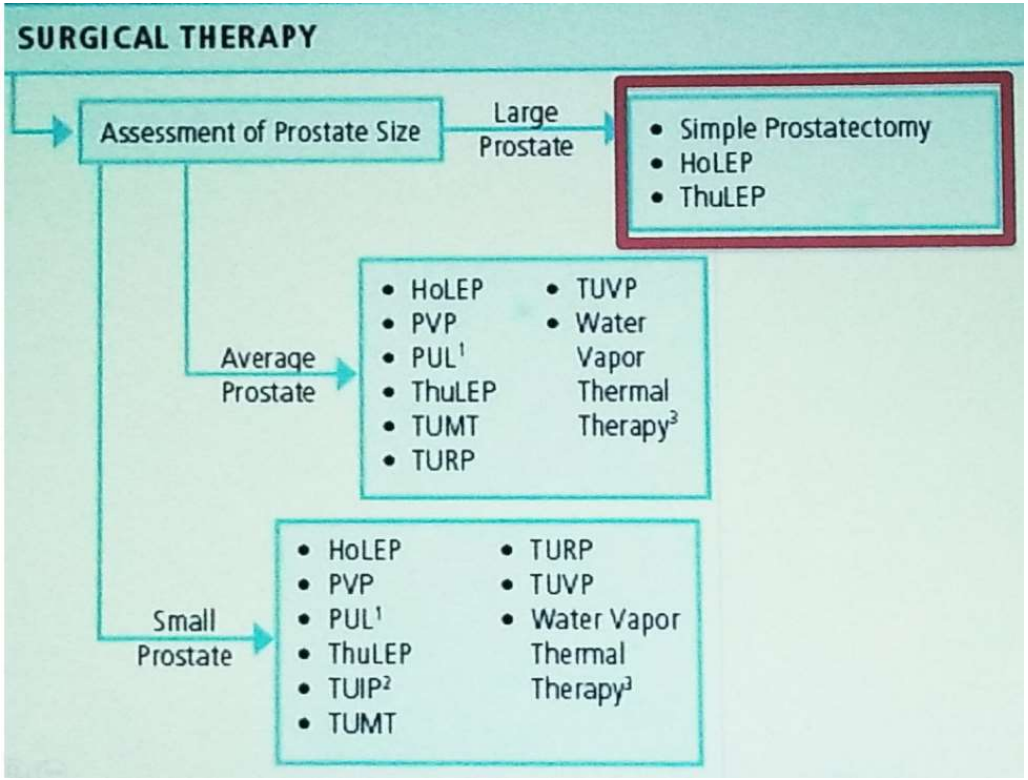
- Risk of incontinence
- Preservation of sexual function both in terms of erection and ejaculation
- Age of the patient and durability of the procedure
- Patient health including ischemic heart disease
- Hospital stay and recovery
- Other complications such as Diverticulum or bladder stones

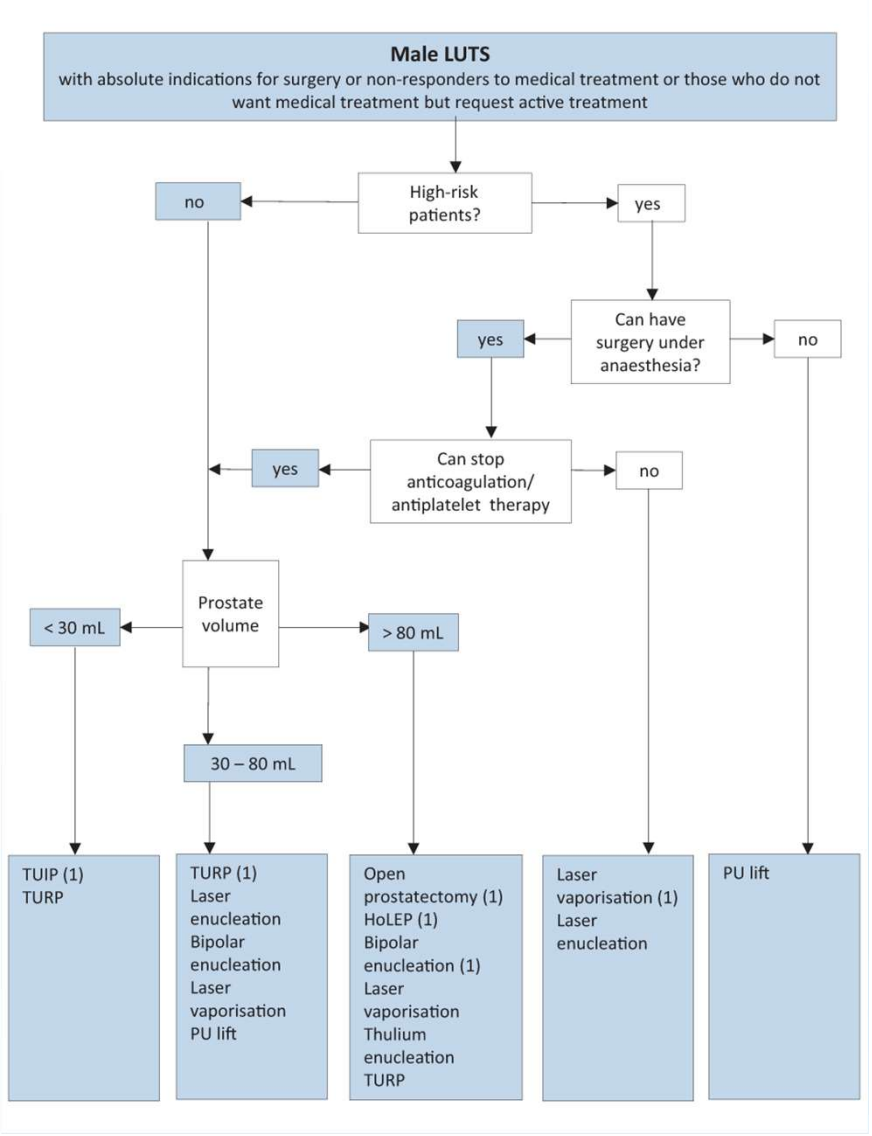
Prostate volume (and shape) – important

A good estimate of prostate volume is critical in determining which treatments can be offered.

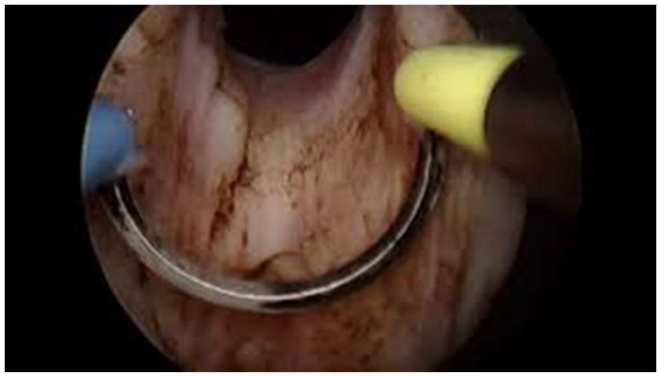
- Digital rectal examination (DRE) - tends to give a rather poor estimate of volume
- MRI is most accurate to determine prostate volume (Expensive). When available or already done for raised PSA - it is very useful to decide BPH surgical options
- Transrectal Ultrasound (TRUS) is the most commonly used method in our unit.
- Flexible cystoscopy is optional and may be needed in some patients when determining the median lobe (particularly for procedures like UROLIFT)

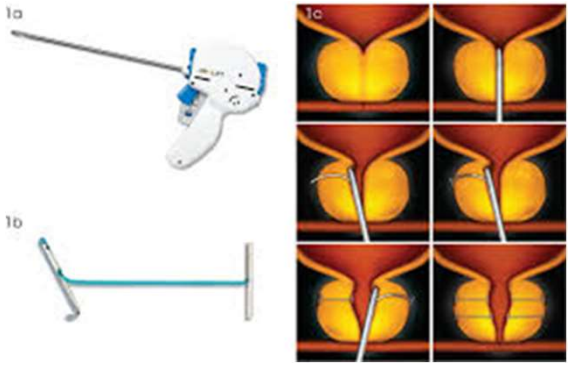
EAU





What we offer in BCH





Prostate Volume	Moderate symptoms IPSS scores: 8 19	IPSS 20 35 Very poor flow rates / high post voids	Other suitable options (not offered in BCH)
Up to 40ml	Urolift (if no significant median lobe) REZUM (when available)	TURP – bipolar / BNI /TUIP GLLP Urolift (can be considered ?)	
40 80 ml	Urolift (exclude significant median lobe) REZUM (when available) GLLP B-TURP (patient choice)	Urolift can be considered (but exclude significant median lobe) REZUM (when available) GLLP B-TURP PAE	
80 100 ml	?GLLP B-TURP	B-TURP GLLP ? (if patient not fit for TURP or on anticoagulant therapy PAE	HoLEP
100 150ml	TURP – staged PAE	TURP – staged PAE	HoLEP
150 200ml	PAE	Staged TURP PAE	HoLEP

It took about a century to change the surgical treatment of benign prostatic hyperplasia (BPH) from open prostatectomy to transurethral resection.

It has taken less than 15 years to develop the more recent MIST

Paradigm shift ? BPH - A more personalized approach now!

Traditional options

- TURP
- BNI/TUIP
- Lasers- GLLP/HOLEP
- Open prostatectomy

Rise of MIST ? (though many under study)

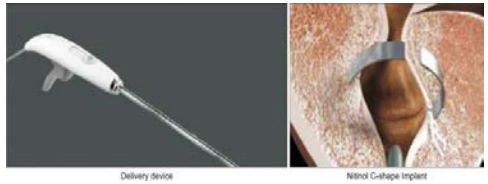
- Mechanical – Urolift, intraprostatic stents, temporary implantable nitinol device
- Botox injections
- PAE
- Water vapour therapy (Rezum)
- Histotripsy
- Aquablation

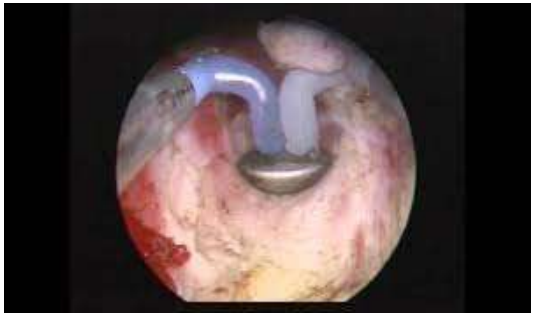

Lumenis
en-bloc HoLEP with
MOSES Technology
Dr. Fernando Gomez Sancha
MOSES
TECHNOLOGY


iTind

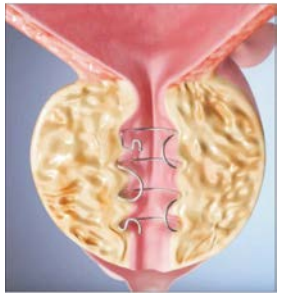

rezūm
Before
After


RevoLix
RevoLix DUO


Delivery device
Nitinol C-shape implant




AQUABEAM
ROBOTIC SYSTEM



Questions to consider – Day case BPH surgery

- Is the need clearly stated?
- Is it in line with the trust's and departments objectives and plans?
- Are the benefits clearly stated?
- Are the demand, capacity and income forecasts robust?

- Are the capital and revenue costs robust?
- Is it clear why the preferred option has been selected?
- Do the main stakeholders support the project?
- Does the team have the capacity and capability to deliver it?
- What is the measure of success?

Staying as we are (not an option)

- Unlikely to make an impact on BPH waiting times (regionally)
- Urgent need to free up beds and theatre capacity
- More emergency admissions and impact on inpatient beds (+ CAUTI in community)
- Poorer outcomes if delayed treatments?
- Patient dissatisfaction / complaints
- Need dedicated purpose built sites for BPH/BOO

Proposal = Regional Day case BPH/BOO service

- Look at current practice in each unit
- Shared learning (good existing practice) – **adapt and adopt**
- **Standardize Pathway LUTS** assessment clinic (Nurse+/-middle grade for DRE) /Uroflowmetry + post void scan
- UDS in select cases
- Plan for Surgery = Prostate volume + shape assessment (to identify suitability for surgical option) by either TRUS or MRI and/or Flexible cystoscopy
- Patient given information/booklets on various BPH modalities (**personalized approach**)
- Patient makes a choice and gets boarded on **regional waiting list**
- Postop dedicated point of contacts

- Cost and efficiency savings for each trust
- Protected funding (elective) – separate stream
- Bed days saving
- Reduced incidence of cancellations once standardized pathways in place
- Reduced waiting times for non cancer surgery
- Improved patient experience
- Reduced complaints

Figure 2: Spending on elective inpatients and day case patients in England, 1998-2014: actual versus estimated amount if day case activity remained at 1998 levels

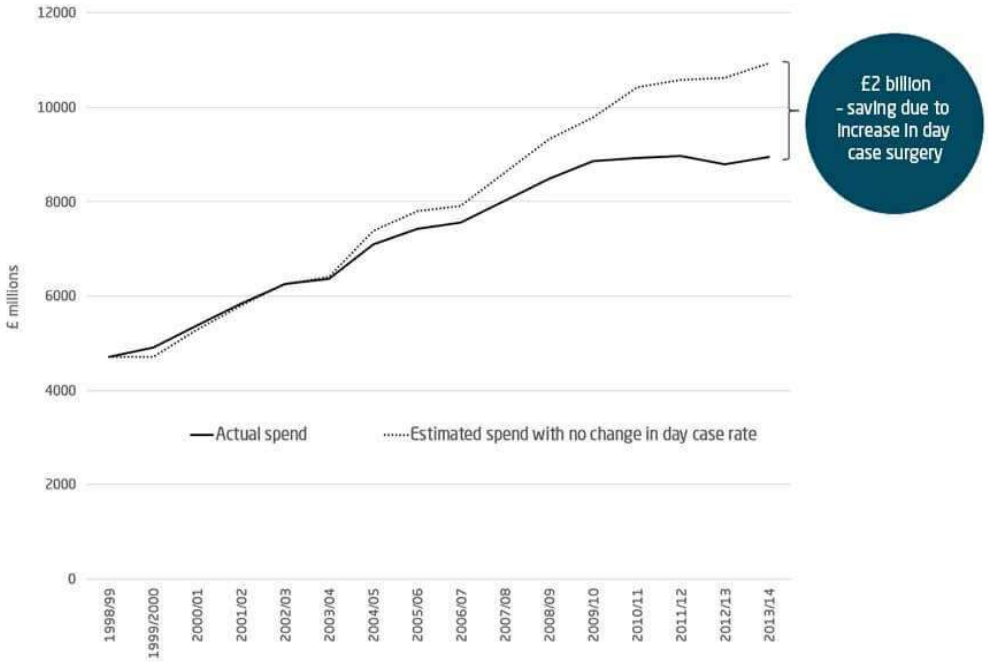
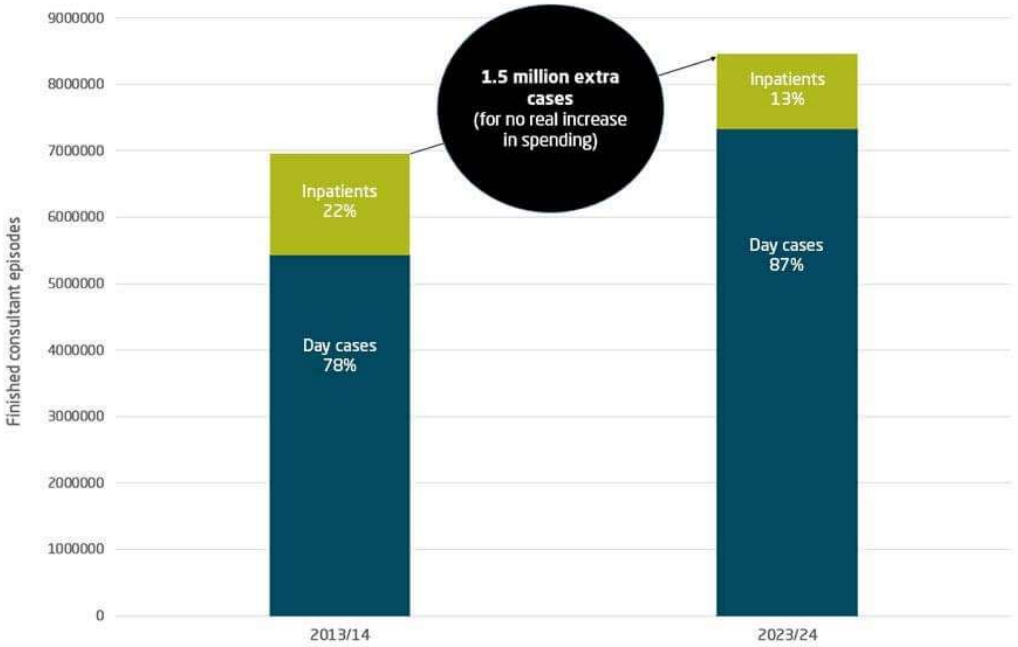


Figure 3: Estimate of number of extra elective patients who could be treated in 2023/24 compared with 2013/14 by gradually increasing the proportion of day case activity to 87 per cent (with no real increase in total spending)



https://www.gov.uk/government/publications/nhs-reference-costs-2013-to-2014

- Creating networks/partnerships
- Regional lead (manager)
- Admin support
- Agreement (amongst urologists) on standardization of pathways and booking system
- Job planning / indemnity (cross trust patients)
- Readmissions post op ?

- Deciding on what we can offer regionally (safely)
- Unfamiliarity with procedures
- New regional pathway agreement with various governance teams (clearly agreed protocols)
- Capital and recurrent (protected) funding – regional ?
- Point of contacts (post op)

Welcome

Stinson, Emma M

From: Emma Giddings (HSCB) <Personal Information redacted by the USI>
Sent: 28 April 2022 10:26
To: David McCormick; 'Harrison, Eric'; 'Alex Macleod'; 'Andrea Turbitt'; 'Brian Duggan'; Christine Allam (SEHSCT); 'Chris Thomas'; 'David Connolly'; 'Elliott, Joanne'; Karen.Personal Information redacted by the USI; Maggie Parks (SEHSCT); 'Mark Haynes'; 'Matthew Tyson'; 'Michael Young'; 'Sam Gray'; 'Tony Glackin'; 'Wendy Clayton'; Mulholland Colin - Consultant
Cc: Director of Strategic Performance PA
Subject: RE: Urology PIG meeting
Attachments: Urology Demand Capacity Review Slides.pptx

Please find attached a copy of the slides presented at this morning's PIG meeting.

Any queries, do not hesitate to contact me.

Emma

Emma Giddings,
Programme Manager
Performance Management & Service Improvement,
Strategic Planning & Performance Group, DoH
M: Personal Information redacted by the USI

From: David McCormick
Sent: 25 April 2022 16:48
To: 'Harrison, Eric'; 'Alex Macleod'; 'Andrea Turbitt'; 'Brian Duggan'; Christine Allam (SEHSCT); 'Chris Thomas'; 'David Connolly'; 'Elliott, Joanne'; Karen.Phelan Personal Information redacted by the USI; Maggie Parks (SEHSCT); 'Mark Haynes'; 'Matthew Tyson'; 'Michael Young'; 'Sam Gray'; 'Tony Glackin'; 'Wendy Clayton'; Mulholland Colin - Consultant; Emma Giddings (HSCB)
Cc: Director of Strategic Performance PA
Subject: RE: Urology PIG meeting

Dear all

Just a quick reminder that the Urology PIG is scheduled for this Thursday at 9.00. Zoom link below

Irrelevant redacted by the USI

The agenda will include:

- LVH regional urology initiative
- CAH ESWL service provision
- Possible regional waiting list for ESWL
- PCNL service
- Omagh Urology expansion
- Capacity/ demand analysis (including pathway analysis)

- Rezum pilot
- IS support in 22/23

Regards
David

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

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Urology Services

Demand Capacity Analysis

Strategic Planning and Performance Group

Health and Social Care

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CONTEXT

Strategic Planning and Performance Group

HSC Health and Social Care

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Performance – 31 day and 62 day targets for Urology

Trust	31 Day			62 Day		
	2019/2020	2020/2021	2021/2022	2019/2020	2020/2021	2021/2022
Belfast	**76%**	**83%**	**89%**	**17%**	**17%**	**6%**
South Eastern	**97%**	**98%**	**96%**	**27%**	**24%**	**32%**
Southern	**99%**	**93%**	**100%**	**41%**	**49%**	**13%**
Western	**100%**	**99%**	**100%**	**49%**	**43%**	**29%**
Region	**89%**	**91%**	**95%**	**32%**	**31%**	**19%**

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DEMAND

Strategic Planning and Performance Group

		FY2019/2020				FY2021/2022 (Up to Jan 22)	
		Total Refs	% Refs	Total Refs	% Refs	Total Refs	% Refs
Belfast	Downgrade RF after Triage	113	1%	86	1%	112	2%
	Red Flag after Triage	3195	39%	2689	41%	2970	41%
	Urgent	2485	31%	2279	34%	2286	31%
	Routine	2334	29%	1575	24%	1923	26%
	Belfast Total	**8127**	31%	**6629**	30%	**7291**	29%
South Eastern	Downgrade RF after Triage	208	4%	116	2%	111	2%
	Red Flag after Triage	2141	39%	2172	45%	2483	46%
	Urgent	1357	25%	1195	25%	1343	25%
	Routine	1781	32%	1379	28%	1489	27%
	South Eastern Total	**5487**	21%	**4862**	22%	**5426**	22%
Southern	Downgrade RF after Triage	227	4%	91	2%	100	2%
	Red Flag after Triage	2063	34%	1800	41%	1904	40%
	Urgent	1839	30%	1121	25%	1034	22%
	Routine	1969	32%	1424	32%	1712	36%
	Southern Total	**6098**	23%	**4436**	20%	**4750**	19%
Western	Downgrade RF after Triage	427	6%	326	5%	401	5%
	Red Flag after Triage	2138	31%	2123	34%	2455	33%
	Urgent	1875	27%	1814	29%	2161	29%
	Routine	2432	35%	1940	31%	2403	32%
	Western Total	**6872**	26%	**6203**	28%	**7420**	30%
	Grand Total	**26584**	100%	**22130**	100%	**24887**	100%

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ACTIVITY

Strategic Planning and Performance Group

RED FLAG New Outpatients (core)

	19/20			20/21			21/22		
	Cons-led	Nurse-led	**Total**	Cons-led	Nurse-led	**Total**	Cons-led	Nurse-led	**Total**
BT	1031	24	**1055**	880	3	**883**	1056	1	**1057**
SET	964		**964**	821		**821**	976		**976**
ST	1741	1	**1742**	1304	12	**1316**	1181		**1181**
WT	659	7	**666**	351	4	**355**	596	1	**597**
Total	4057	32	**4089**	3356	17	**3375**	3809	2	**3811**

URGENT New Outpatients (Core)

	19/20			20/21			21/22		
	Cons-led	Nurse-led	**Total**	Cons-led	Nurse-led	**Total**	Cons-led	Nurse-led	**Total**
BT	1551	100	**1651**	1592	74	**1666**	1123	106	**1229**
SET	521	14	**535**	759	20	**779**	723	64	**787**
ST	1187	5	**1192**	330	5	**335**	372	56	**428**
WT	888	350	**1238**	720	229	**949**	855	528	**1383**
Total	4147	469	**4616**	3401	328	**3729**	3073	754	**3827**

ROUTINE New Outpatients (Core)

	19/20			20/21			21/22		
	Cons-led	Nurse-led	**Total**	Cons-led	Nurse-led	**Total**	Cons-led	Nurse-led	**Total**
BT	730	366	**1096**	210	165	**375**	130	178	**308**
SET	341	158	**499**	565		**565**	472	19	**491**
ST	611	118	**729**	752	11	**763**	670	110	**780**
WT	1306	878	**2184**	1019	446	**1465**	1261	481	**1742**
Total	2988	1520	**4508**	2546	622	**3168**	2533	788	**3321**

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RED FLAG Review Outpatients (core)

	18/19			19/20		
	Cons-led	Nurse-led	**Total**	Cons-led	Nurse-led	**Total**
BT	480	10	**490**	357	10	**367**
SET	591	0	**591**	693	0	**693**
ST	685	3	**688**	620	2	**622**
WT	396	428	**824**	401	395	**796**
TOTAL	2152	441	**2593**	2071	407	**2478**

URGENT Review Outpatients (Core)

	18/19			19/20		
	Cons-led	Nurse-led	**Total**	Cons-led	Nurse-led	**Total**
BT	2889	200	**3089**	1679	92	**1771**
SET	1349	14	**1363**	1357	1	**1358**
ST	1686	5	**1691**	1614	106	**1720**
WT	894	329	**1223**	866	795	**1661**
TOTAL	6818	548	**7366**	5516	994	**6510**

ROUTINE Review Outpatients (core)

	18/19			19/20		
	Cons-led	Nurse-led	**Total**	Cons-led	Nurse-led	**Total**
BT	5756	597	**6353**	6369	759	**7128**
SET	1624	3	**1627**	1311	7	**1318**
ST	1843	408	**2251**	2075	477	**2552**
WT	2319	3437	**5756**	1913	2950	**4863**
TOTAL	11542	4445	**15987**	11668	4193	**15861**

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Review Waiting List @ 4th May 2020

Trust	0-3mths	3-6mths	6-9mths	9-12mths	12-15mths	15-18mths	18-21mths	21-24mths	GT 24mths	**Total**	Backlog
Belfast	367	140	80	24	1					**612**	245
South Eastern	433	307	119	52	44	37	1			**993**	560
Southern	419	336	293	273	298	271	194	267	859	**3210**	2791
Western	461	83	14						1	**559**	98
Total	1680	866	506	349	343	308	195	267	860	**5374**	3694

Time band = length of time waiting beyond clinically indicated review date
Backlog = > 3 months

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Independent Sector Outpatient Activity

Fiscal Year	Belfast		Southern		Total
	New	Review	New	Review	
2018/2019	41	5			46
2019/2020	36	117			153
2020/2021	79	1		179	259

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RED FLAG New Outpatients (WLI)

	18/19			19/20		
	Cons-led	Nurse-led	Total	Cons-led	Nurse-led	Total
BT	347	0	347	95	0	95
SET	297	0	297	98	0	98
ST	48	0	48	145	0	145
WT	0	0	0	0	0	0
Total	692	0	692	338	0	338

RED FLAG Review Outpatients (WLI)

	18/19			19/20		
	Cons-led	Nurse-led	Total	Cons-led	Nurse-led	Total
BT	4	2	6	0	5	5
SET	11	0	11	0	0	0
ST	4	0	4	0	22	22
WT	0	0	0	0	0	0
Total	19	2	21	0	27	27

URGENT New Outpatients (WLI)

	18/19			19/20		
	Cons-led	Nurse-led	Total	Cons-led	Nurse-led	Total
BT	32	0	32	6	12	18
SET	148	0	148	70	0	70
ST	0	0	0	13	0	13
WT	0	0	0	0	0	0
Total	180	0	180	89	12	101

URGENT Review Outpatients (WLI)

	18/19			19/20		
	Cons-led	Nurse-led	Total	Cons-led	Nurse-led	Total
BT	12	25	37	0	41	41
SET	28	0	28	0	0	0
ST	13	0	13	32	0	32
WT	63	0	63	9	0	9
Total	116	25	141	41	41	82

ROUTINE New Outpatients (WLI)

	18/19			19/20		
	Cons-led	Nurse-led	Total	Cons-led	Nurse-led	Total
BT	224	0	224	1	59	60
SET	168	0	168	12	0	12
ST	0	0	0	0	0	0
WT	0	0	0	0	0	0
Total	392	0	392	13	59	72

ROUTINE Review Outpatients (WLI)

	18/19			19/20		
	Cons-led	Nurse-led	Total	Cons-led	Nurse-led	Total
BT	42	16	58	0	89	89
SET	104	0	104	0	0	0
ST	54	0	54	161	0	161
WT	90	0	90	19	0	19
Total	290	16	306	180	89	269

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

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OP Referrals v OP Attendances (%)

	New OP Referrals (All)			New OP Attendances (All)			%		
	19/20	20/21	21/22	19/20	20/21	21/22	19/20	20/21	21/22
BT	8127	6629	7291	3838	3005	2751	47.2	45.3	37.7
SET	5487	4862	5426	1998	2165	2254	36.4	44.5	41.5
ST	6098	4436	4750	3663	2414	2410	60.1	54.4	50.7
WT	6872	6203	7420	4128	2777	3748	60.1	44.8	50.5

	New OP Referrals (Red Flag)			New OP Attendances (Red Flag)			%		
	19/20	20/21	21/22	19/20	20/21	21/22	19/20	20/21	21/22
BT	3195	2689	2970	1055	883	1057	33.0	32.8	35.6
SET	2141	2172	2483	964	821	976	45.0	37.8	39.3
ST	2063	1800	1904	1742	1316	1201	84.4	73.1	63.1
WT	2138	2123	2455	666	355	597	31.2	16.7	24.3

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Elective IPDC – Suspected Cancer 'Direct to Scope'

	19/20	20/21	21/22
BT	2411	2028	1764
NT	886	574	822
SET	1161	1136	1237
ST	-	3	11
WT	1179	1179	1182

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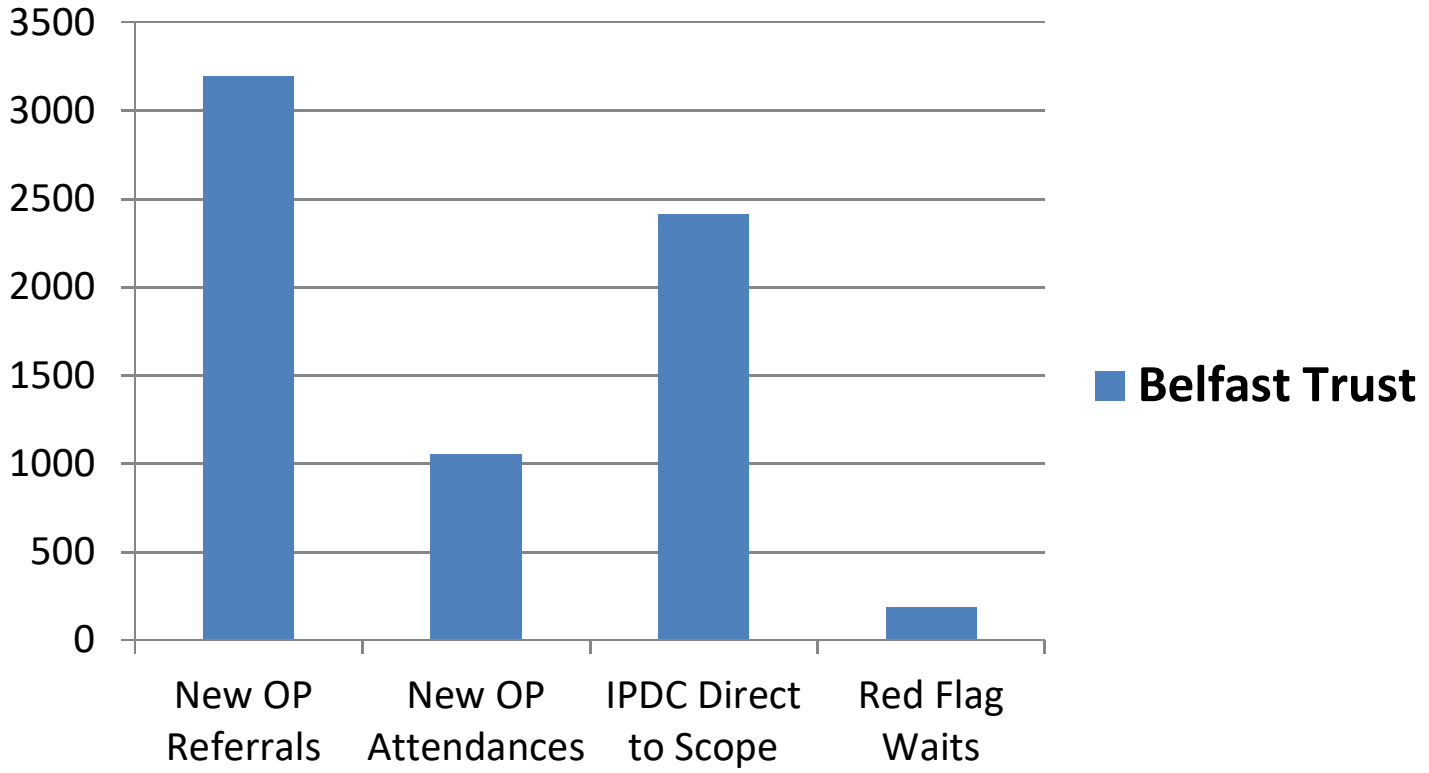
2019/2020 'Red Flag'



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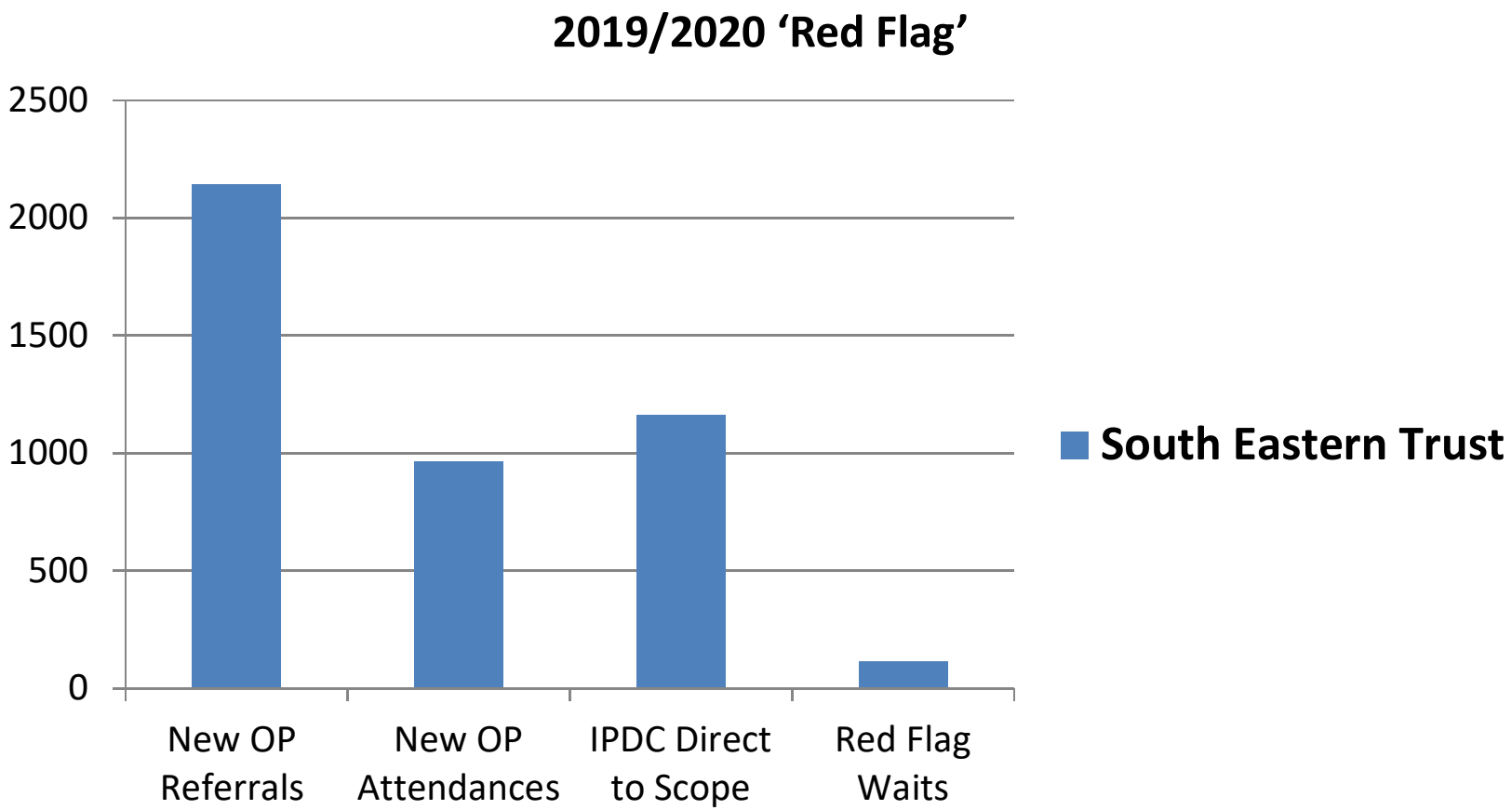

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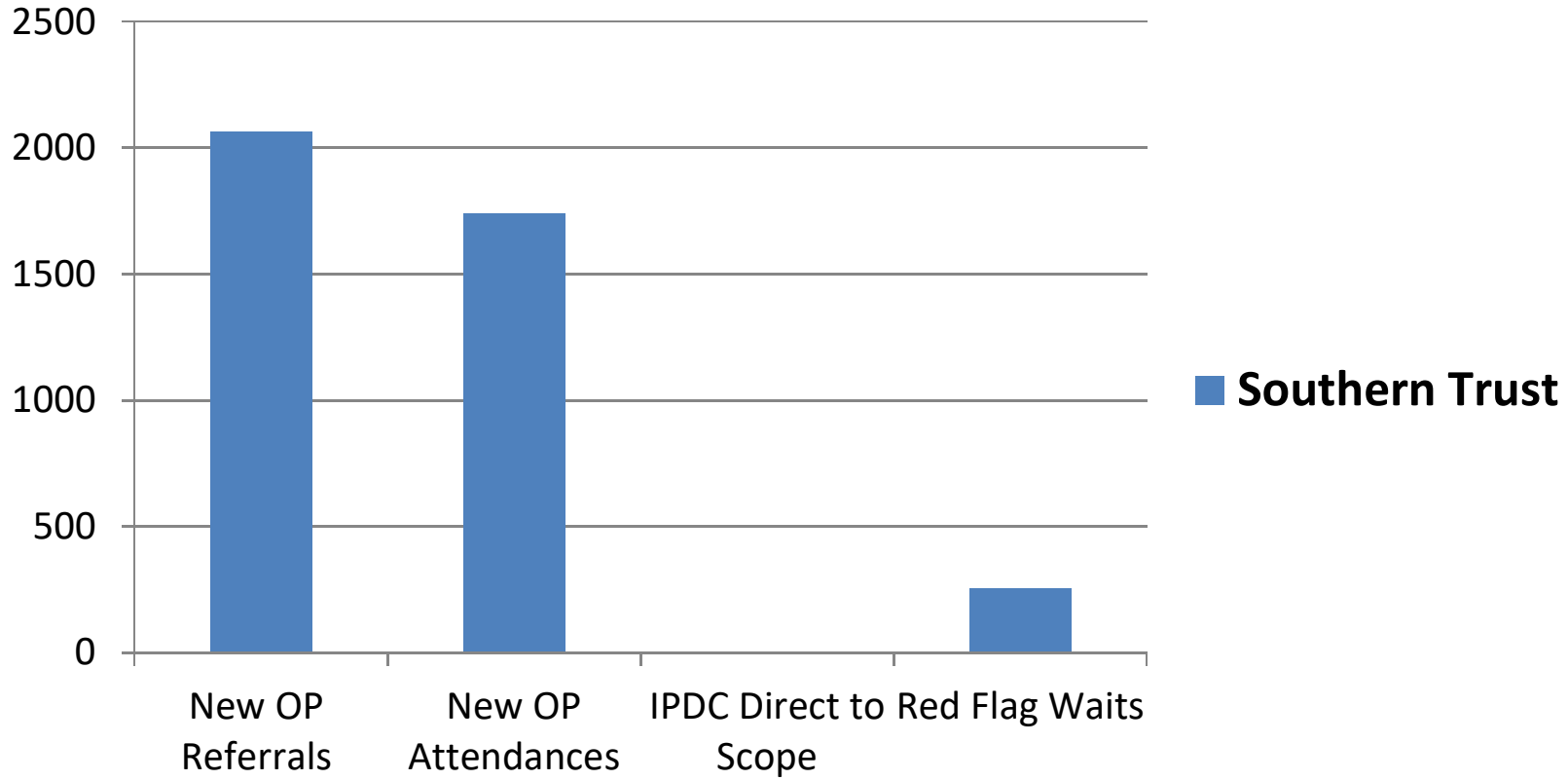

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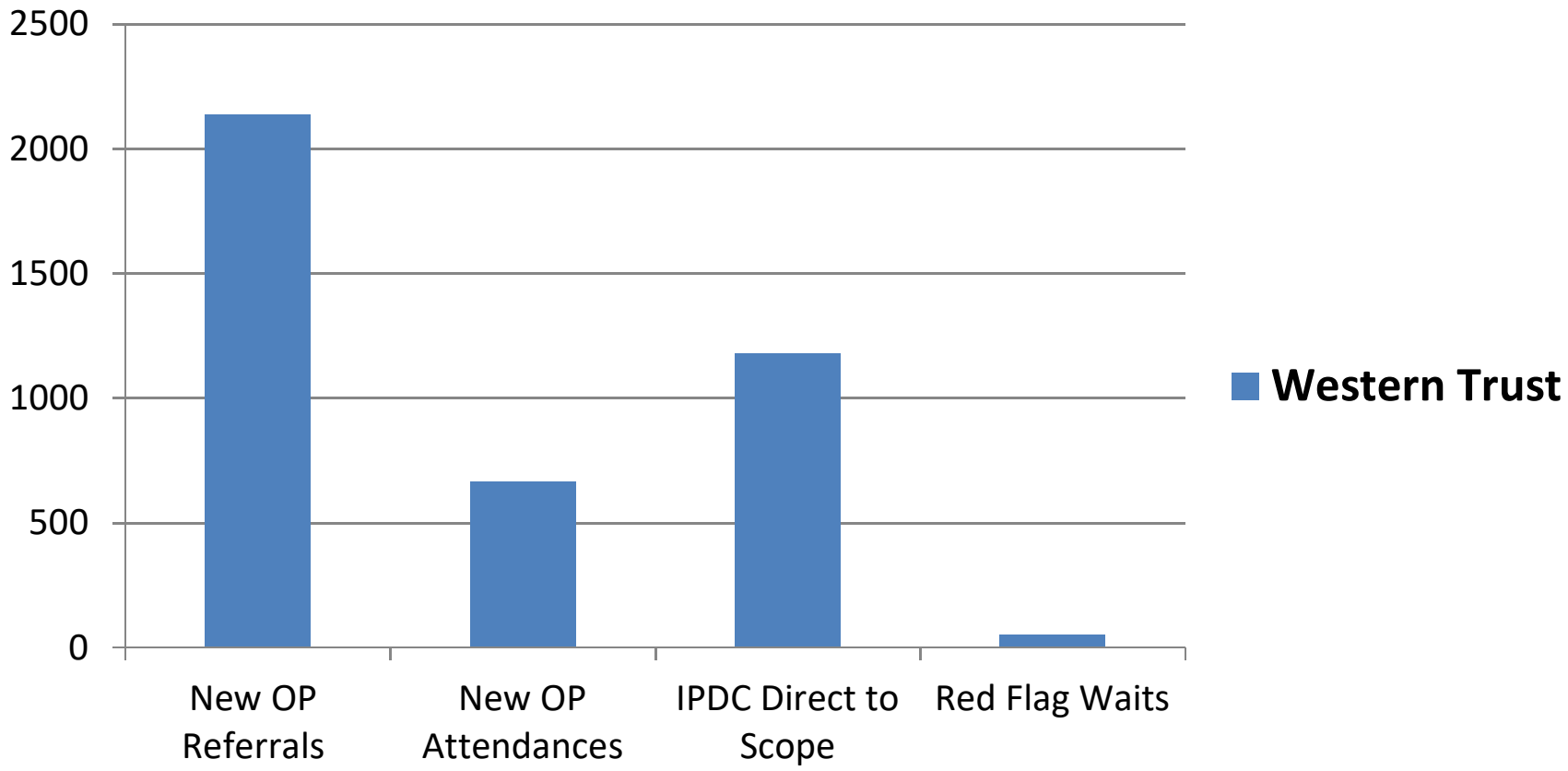

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CAPACITY

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Staffing Profile (WTE)

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	Consultants	Staff Grades	Specialist Registrars	Clinical Fellows	Specialist Nurses
Belfast - Funded	9.0	1.0	5.0	2.0	2.0 benign 2.0 uro-oncology
Variance to funded	8.0 + 1.0 locum				
South East - Funded	6.0	3.0	1.0		1.85 benign 1.85 uro-oncology
Variance to funded	5.0 + 1.0 locum (NF)	2.0 (1 vacancy)			
Southern - Funded	7.0	2.0	3.0	1.0	2.0 benign 3.0 uro-oncology
Variance to funded	4.3 + 1.0 locum	1.8	2.0 (1 mat leave)	3.0 (SHO-grade)	
Western - Funded	8.0	2.0	2.0	1.0	6.8 benign 3.0 uro-oncology
Variance to funded		3.0			

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Urology Services Outpatient Clinic Capacity - Belfast

Types of clinics PER WEEK	Clinics	Slots		Total Slots	Weeks/ year		Additional Clinics	Slots	Weeks per year
		New	Review						
Virtual (Tues AM) (AR)	1	8-10		8-10	42		Raised PSA 2 x SG- 1 x CL	8-10	Ad hoc
Friday AM (AR) FTF	1	8-10		8-10	42		2 x Haematuria (W'abbey)	10-12	Ad hoc
CONURO3	1	20		20	42				
CONUR3VC	1	10		10	42				
THOT4	1	10		10	42				
THOTELR	1	10		10	42				
THOTAAH2	1	10		10	42				
OKANUR2	1	5		5	42				
OKANUR2VC	1	10		10	42				
OKRES3VC	1	10		10	42				
OKUROTEL	1	10		10	42				
OKRES5VC	1	10		10	42				
OKAUR5AM	1	6		6	42				

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Urology Services Outpatient Clinic Capacity - Belfast

Types of clinics PER WEEK	Clinics	Slots		Total Slots	Weeks / year		Additional Clinics	Slots	Weeks per year
		New	Review						
Results clinic (Cur)	2	10-12		20-24	42				
Review/New/FTF (Cur)	1	18		18	42				
Beekharry results Clinic	2	20		40	42				
Beekharry New patients	1	12	-	12	42				
Haynes Results Clinic	0.5	12	-	6	26				
Review Clinic AP	1	-	15	15	42				
FTF N&R	1	12		12	42				
PAC1 – new		7	-	7	40				
PAC3 – new	1	7	-	7	42				

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Urology Services Clinic Capacity – South Eastern

No./Types of clinics PER WEEK	clinics	Slots new	Slots review	total slots	Core Weeks/ year		Additional Clinics	Slots	Weeks per Year
Mr Gray F2F ARDS	1	6	8	14	42		WLI Urology x 4		Ad hoc
Mr Gray Virtual UHD	1	4	12	16	42		WLI Virtual Urology x 2		Ad hoc
Ms Dooher F2F UHD	1	6	8	14	42		Mr Hutton Prostate Clinic UHD	8	
Ms Dooher Virtual UHD	1	4	12	16	42				
Mr Abogunrin F2F	0.5	6	6	6	42				
Mr Abogunrin Virtual	0.75	6	6	9	42				
Mr Abogunrin F2F LVH	0.5	4	2	3	42				
Mr Abogunrin Virtual)	1		6-12	6-12	42				
Ms Hutton F2F Bangor	1	6	7	13	42				
Ms Hutton Virtual UHD	1	6	8	14	42				

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Mr Duggan F2F	1	5	3	8	42
Mr Duggan Virtual DH	0.25	6	7	3.25	42
Mr Duggan Virtual UHD	1	6	7	13	42
Mr McKnight F2F UHD	1	4	8	12	42
Mr McKnight Results DOSA	0.25	0	1	0.25	42
Mr McKnight Virtual	0.25	4	8	3	42
Nurse Urology F2F Ards	1	3	4	7	42
Nurse Urology Medical Device Clinic F2F Ards	0.25	3	4	1.75	42
Nurse Urology Virtual	1	0	2	2	42
Nurse Urology Ward 7 Treatment Room	0.25	0	9	2.25	42
Nurse Urology Virtual Ards	1	5	2	7	42
Nurse Urology F2F DOSA	1	6	0	6	42
Nurse Urology Virtual UH	0.25	0	12	3	42
Nurse Urology Virtual UH	0.25	0	12	3	42
Nurse Urology Virtual UHD	1	5	5	10	42

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Urology Services Clinic Capacity - Southern

No./Types of clinics PER WEEK	clinics	Slots New	Slots Review	total slots	Weeks/ year		Additional Clinics	Slots	Weeks per Year
New Haematuria	5.5	10		55	34 (CL) 42 (NL)		Ad hoc to cover core clinics		Up to 50 weeks
Review Clinic	5.5		12	66	32 (CL)				
Review Virtual Clinic	1		35	35	35				
New Virtual Clinic	1	7		7	35				

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Urology Services Clinic Capacity - Western

No./Types of clinics PER WEEK	Clinics	Slots		Total Slots	Core Weeks/ year		Additional Clinics	Slots	Weeks per Year
		New	Review						
Consultant Clinics	13	6	9	195	41				
Registrar Clinics	3	6		18	41				
Specialty Doctor Clinics	2	10		20	41				
Specialty Dr – ED	1	7		7	41				
Prostate Clinic (Nurse-led)	10	3	4	70	46				
Urodynamics (Nurse-led)	3	2		6	46				
Catheter (Nurse-led)	6	2	3	30	46				
TW Catheter (Nurse-led)	1	3		3	46				
Kidney Stone	3		8	24	46				
Upper Trace Surveillance	0.5		8	4	46				
Video Urodynamics	0.5		2	1	46				
Sacral Nerve Stimulation	0.5	7		3.5	46				

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Urology Services Procedures Capacity

Flexible Cystoscopy Procedures PER WEEK	Lists/ Sessions	Slots	Total Slots	Weeks per year
Belfast	4	11	44	42
South Eastern	1	100	100 (+100)	42
Southern	5*	10	50	42
Western	10	10	100	50

* 3 = theatres
2= outpatients

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Urology Services Procedures Capacity

TP Biopsy Procedures PER WEEK	Lists/ Clinics	Slots	Total Slots	Weeks per year
Belfast	3	6	18	42
South Eastern	1	6	6	42
Southern	1-2	6	6-12	42
Western	2	7	14	50

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VARIATION

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New OP % discharged immediately after 1st OPA (Red Flag)

(All activity inc Cons/CNS/IS/ICAT) (Same OPA & Discharge Date)

	19/20	20/21	21/22 (up to Jan 22)
Belfast – OPA Attendances	1055	833	1057
No. discharged at 1st OPA	336	122	185
	32%	**15%**	**18%**
South East– OPA Attendances	964	821	976
No. discharged at 1st OPA	20	83	43
	2%	**10%**	**4.4%**
Southern– OPA Attendances	1742	1316	1201
No. discharged at 1st OPA	615	431	488
	35%	**33%**	**41%**
Western– OPA Attendances	666	355	597
No. discharged at 1st OPA	6	16	-
	1%	**4.5%**	**-**

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Referrals Discharged without Attendance	Belfast	South Eastern	Southern	Western	Northern	Grand Total
FY2019/2020	3162	2121	2028	1756	17	9084

Discharge Grouping	Belfast	South Eastern	Southern	Western	Northern	Grand Total
ADD TO IPDC WL	2052	1227	351			3630
DISCHARGE TO REFERRER	165	257	777	109		1308
DIRECT ACCESS				1017		1017
DISCHARGE BY CONSULTANT	106		416	227		749
DISC AWAITING RESULT OP \ DIAG	67	207	111	266		651
TRANSFER CONSULTANT	371	145	10		16	542
DISCHARGE TO OTHER SERVICE	163	99	192	11		465
FOLLOWING VALIDATION	10	78	62	41		191
Automatic Discharge (Sys def)	20	24	43	56		143
TREATMENT COMPLETE	106	5		4	1	116
TREATED ELSEWHERE	27	40	24			91
AT PATIENTS REQUEST	9	16	13	11		49
DUPLICATE	43	2	4			49
DNA \ CND	15	3	8	12		38
ADMIT \ TREATED AS IP\ WA	2		16	2		20
REFUSED OFFER OF APPOINTMENT		17	1			18
ADD TO OP WL	5					5
OTHER	1					1
PATIENT AWAITING PROCEDURE		1				1
Grand Total	**3162**	**2121**	**2028**	**1756**	**17**	**9084**

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DNA & CND Rates

	All Activity: Urology	FY2019/2020 DNA+CND Rate	FY2020/2021 DNA+CND Rate	FY2021/2022 (Up to Jan 22) DNA+CND Rate
Belfast	Consultant-Led	9.5%	11.1%	7.9%
	Nurse-Led	8.8%	14.2%	8.1%
	Belfast Total	**9.3%**	**11.1%**	**7.6%**
South Eastern	Consultant-Led	6.0%	11.3%	11.8%
	Nurse-Led	16.9%	0.0%	15.3%
	South Eastern Total	**7.1%**	**11.2%**	**12.0%**
Southern	Consultant-Led	5.3%	1.7%	2.5%
	Nurse-Led	3.1%	0.0%	4.0%
	Southern Total	**5.2%**	**1.7%**	**2.9%**
Western	Consultant-Led	14.2%	10.3%	10.2%
	ICATS-Led	13.0%	11.1%	25.7%
	Nurse-Led	16.7%	10.7%	13.7%
	Western Total	**14.9%**	**10.4%**	**11.3%**
	Grand Total	**9.7%**	**8.9%**	**8.8%**

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DNA & CND Rates

Red Flag after Triage: Urology

				FY2021/2022 (Up to Jan 22)
				DNA+CND Rate
Belfast	Consultant-Led	5.1%	7.5%	4.9%
	Nurse-Led	4.0%	0.0%	50.0%
	Belfast Total	**5.0%**	**7.4%**	**4.9%**
South Eastern	Consultant-Led	4.7%	4.5%	4.9%
	South Eastern Total	**4.7%**	**4.5%**	**4.9%**
Southern	Consultant-Led	5.0%	2.6%	2.5%
	Nurse-Led	0.0%	0.0%	
	Southern Total	**5.0%**	**2.6%**	**2.9%**
Western	Consultant-Led	8.6%	7.6%	6.1%
	Nurse-Led	0.0%	0.0%	0.0%
	Western Total	**8.5%**	**7.6%**	**6.1%**
	Grand Total	**5.5%**	**4.9%**	**4.5%**

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PATIENT PATHWAYS

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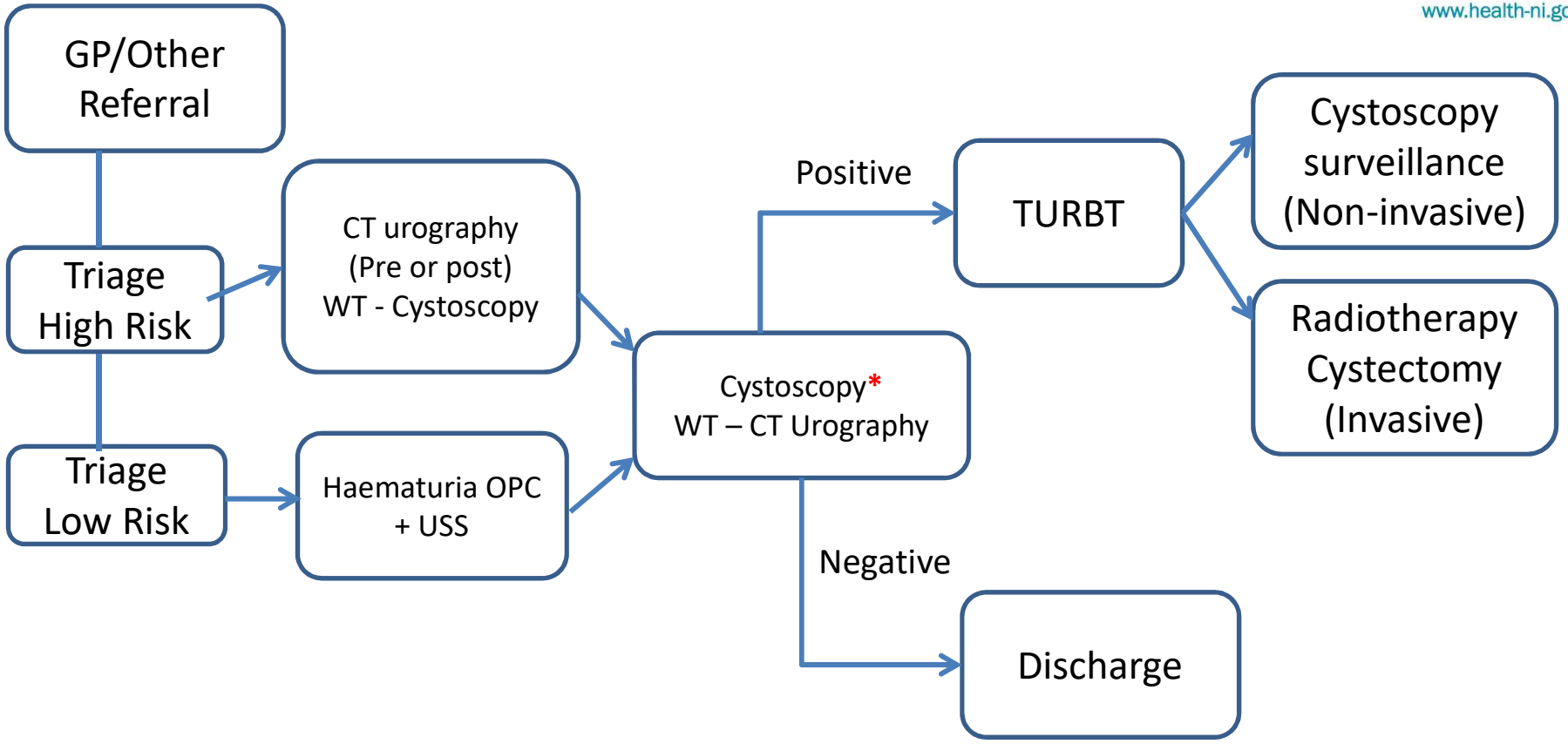
Haematuria Pathway



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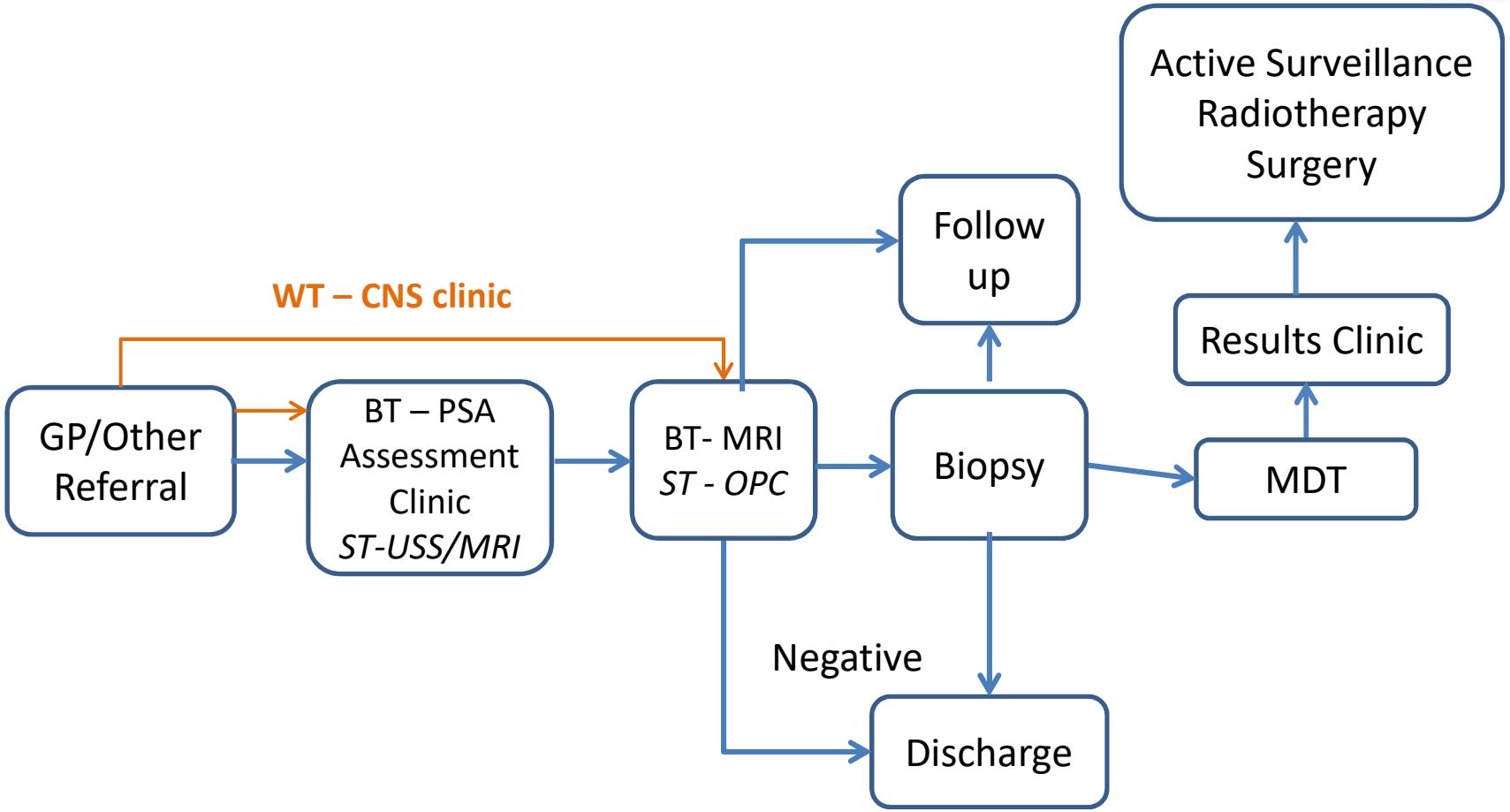
Raised PSA Pathway



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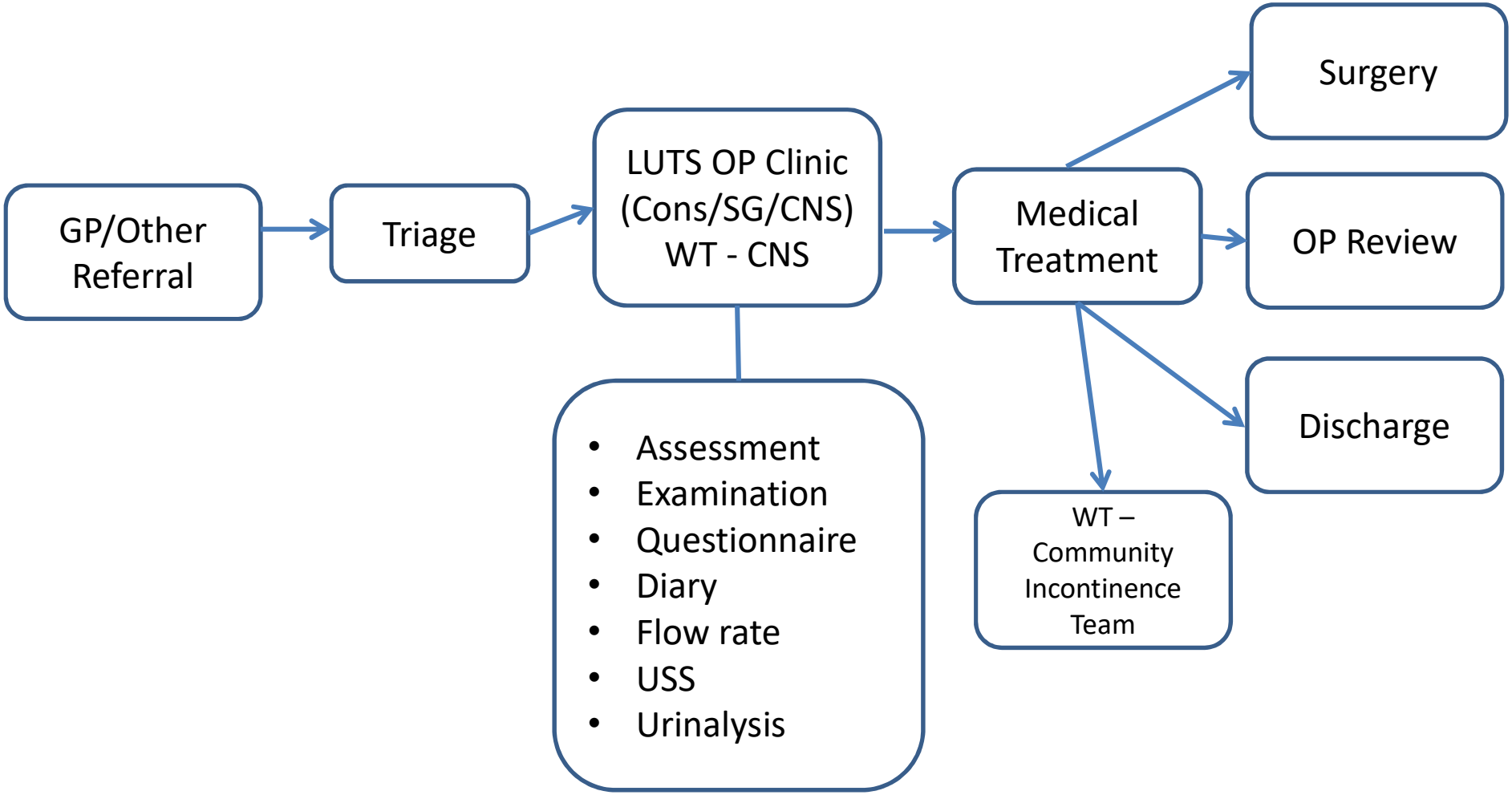
Lower Urinary Tract Symptoms Pathway



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SUMMARY

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Performance	• 62-day performance:	19/20 **32%**	20/21 **31%**	Feb 2022 **19%**
Demand	• BT & WT receive approx 30% referrals • SET & ST receive approx 20% referrals			
Activity	• ST Red Flag New Outpatient Attendance high • All Trusts decrease in activity in 20/21 • Further decrease in activity 21/22 for BT & ST			
Review Waits	• May 2020	ST backlog 2791		
	• Apr 2022	ST backlog 1169	BT backlog 1126	
Clinics	• Higher % RF referrals attend OPC in ST	19/20 84.4%	20/21 73.1%	21/22 63.1%
CNS Roles	• WT CNS team = 9.80 WTE	WT have highest OP capacity		
Pathways	• Flexible cystoscopy performed in non-theatre settings	• Scope of CNS	• Return to OPC for results	

Strategic Planning and Performance Group

Southern Health and Social Care Trust

Divisional Medical Director Review Meeting

Divisional Medical Director	
Division	
Meeting Date	

Southern Health and Social Care Trust

Professional Governance

1. Job Planning	
Current Status	
Discussion	*e.g. Issues delaying job planning activities, staff absences, discussion of additional supports required*
Agreed Actions	•

2. Medical Appraisal	
Current Status	**Example below:** **Appraisal Year 2020**
Discussion	*e.g. Issues delaying appraisals, staff absences, discussion of additional supports required*
Agreed Actions	•

3. Revalidation	
Current Status	**Total Number of Divisional Doctors Requiring Revalidation in Year:** **Total Number of Divisional Doctors Revalidated In Year:** **Total Number of Divisional Doctors with Deferred Revalidation Date:**
Discussion	*e.g. Issues delaying revalidation, staff absences, reasons for deferrals, any concerns with staff meeting required deadlines*
Agreed Actions	•

4. Professional Performance Management	
Current Status	**Total Number of Divisional Doctors Performance Management Reviews in Year:** **Total Number of Divisional Doctors Undertaken Performance Management Reviews In Year:**
Discussion	*e.g. Issues delaying revalidation, staff absences, reasons for deferrals, issues identified via professional performance management*
Agreed Actions	

5. Medical Workforce

Current Status

Specialty 1

	Substantive Posts	Locum Posts
Number of funded Consultant Posts		
Number of funded SAS Posts		
Number of Training Grade Posts		

Details of Posts Actively Being Recruited:

Specialty 2

	Substantive Posts	Locum Posts
Number of funded Consultant Posts		
Number of funded SAS Posts		
Number of Training Grade Posts		

Details of Posts Actively Being Recruited:

Discussion

e.g. Issues delaying recruitment, efforts to make posts substantive , areas of short staffing, mitigation steps taken, escalation of issuesetc

Agreed Actions

-

6. Doctors and Dentists Oversight	
Current Status	
Discussion	*e.g. Issues identified from DDOG meeting, other issues arising that may need addressed, doctors in difficulty*
Agreed Actions	•

Southern Health and Social Care Trust

Clinical and Social Care Governance

1. Adverse Incidents (Datix)

Current Status

Reported Incidents

	Signed off	Not Signed Off	Total
Number of Catastrophic Incidents this Quarter (Oct – Dec)			
Number of Major Incidents this Quarter (Oct – Dec)			
Number of Moderate Incidents this Quarter (Oct – Dec)			
Number of Minor Incidents this Quarter (Oct – Dec)			

Medication Incidents

Discussion

e.g. trends in incidents, learning from incidents, quality improvemen intiatives, where further support is required etc

Agreed Actions

-

2. Serious Adverse Incidents

Current Status

More than 26 weeks	Less than 26 weeks	Within Timescales	Level 3	Total

New SAIs This Quarter (Oct – Dec)	Governance Team Update

Ongoing SAIs	Update

Discussion

e.g. trends in SAIs, learning from SAIs, quality improvemen intiatives, where further support is required

Agreed Actions

- .

3. Litigation and Claims Management	
Current Status	
Discussion	*e.g. trends in litigation, learning from litigaion, quality improvemen intiatives, where further support is required etc* .
Agreed Actions	•

4. Coronial Matters	
Current Status	
Discussion	*e.g. trends in coronial reports, learning from coronial reports, quality improvemen intiatives, where further support is required etc*
Agreed Actions	•

5. Standards and Guidelines	
Current Status	**Standards and Guidelines relevant to Division**
Discussion	*e.g. progress with regards to S&G implementation, resourcing issues, quality improvemen intiatives, where further support is required etc*
Agreed Actions	•

6. Complaints	
Current Status	
Discussion	*e.g. Issues delaying recruitment, efforts to make posts substantive , areas of short staffing, mitigation steps taken, escalation of issuesetc*
Agreed Actions	•

7. Morbidity and Mortality

Current Status

Divisional M&M Activity

Number of Inpatient Deaths In Period		
Number of Inpatient Deaths where a Statement of Management has been completed		
Number of Inpatient Deaths signed off by M&M Chair		
Number of Inpatient Deaths Selected for Detailed Presentation at M&M Meeting		
Average number of days between Inpatient Death and Statement of Management Complete		
Statement of Management	No. Signed off and Discussed in Detail at M&M	No. Signed off and Discussed in Detail at M&M
SOM 1 -Was Satisfactory – there were no particular learning lessons		
SOM 2 - Contained aspects that COULD be improved (learning identified) the patients eventual outcome was NOT affected		
SOM 3 - Contained aspects that SHOULD be improved (learning identified) the patient's eventual outcome was NOT affected i.e. near miss. Consider referring to Trust Incident Reporting System unless already considered or reported		
SOM 4- Contained aspects that have already been or SHOULD be referred to Trust Incident Reporting System		
SOM 5 - Contained aspects that were Exemplary and the learning SHOULD be shared appropriately		

Discussion

e.g. Issues delaying recruitment, efforts to make posts substantive , areas of short staffing, mitigation steps taken, escalation of issuesetc

Agreed Actions

8. Clinical Audit and Quality Improvement	
Current Status	**<u>Clinical Audit</u> – Focus for this meeting – Local and National Audit participation** **National Audits:** **Local Audits:**
Discussion	

9. Patient Safety	
Current Status	•
Discussion	
Agreed Actions	•

10. Signed off results	
Current Status	
Discussion	
Agreed Actions	•

Other Issues

11. Medical Education	
Current Status	
Discussion	
Agreed Actions	•

12. Research and Development	
Current Status	**Ongoing Reseach and Development Projects in Division** • **A** • **B** • **C** • **D**
Discussion	
Agreed Actions	•

13. Quality Improvement	
Current Status	
Discussion	• What are you most proud of this month?
Agreed Actions	•

14. Issues for discussion this month	
Current Status	
Discussion	
Agreed Actions	•

Datix

Personal information redacted by USI

SHSCT GOVERNANCE TEAM (IR2) Form -NEW June 2018

Incident Details
ID & Status

Incident Reference ID	Personal Information redacted by USI
Submitted time (hh:mm)	07:37

Incident IR1 details

Notification email ID number	Personal information redacted by
Incident date (dd/MM/yyyy)	17/07/2018
Time (hh:mm)	12:00
Description Enter facts, not opinions. Do not enter names of people	Inpatient admission 2 Personal information redacted by USI FU CT Renal in 3 months. CT performed 1 Personal information (reported 20/3/18) showed suspected renal cancer. GP referral 17/7/18 as no review / FU had occurred after CT scan. Subsequently underwent surgical treatment of renal cancer.
Action taken Enter action taken at the time of the incident	Upon receipt of referral, OP assessment and further management was arranged.
Learning Initial	Robust mechanisms for clinican review and action of results is required.
Reported (dd/MM/yyyy)	12/03/2019
Reporter's full name	Mark Haynes
Reporter's SHSCT Email Address	Personal Information redacted by the USI
Opened date (dd/MM/yyyy)	12/03/2019
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 92
Type	Incidents affecting Patients / Clients / Service Users: PATNT

Location of Incident

Site	Craigavon Area Hospital: CAH
Loc (Type)	Outpatient Clinic: OUTCLI
Loc (Exact)	Urology Clinic: UROLOG
Directorate	Acute Services: ACUTE
Division	Surgery and Elective Care: SEC
Service Area	General Surgery: GENSUR
Speciality / Team	Urology Surgery: UROSUR

Staff initially notified upon submission

Recipient Name	Recipient E-mail	Date/Time	Contact ID	Telephone Number	Job Title
Carroll, Ronan	Personal Information redacted by the USI	12/03/2019 07:37:52	Personal Information redacted by the USI		Assistant Director of Acute Services
Kelly, Brigeen		12/03/2019 07:37:52			Head of Trauma and Orthopaedics
Young, Michael		12/03/2019 07:37:52			Consultant
Haynes, Mark Mr		12/03/2019 07:37:52			Consultant Urologist
McAloran, Paula		12/03/2019 07:37:52			Senior Governance Officer
Kingsnorth, Patricia Mrs		12/03/2019 07:37:52			Acute Governance Co-Ordinator
Corrigan, Martina		12/03/2019 07:37:51			Head of ENT and Urology

Management of Incident

Handler Enter the manager who is handling the review of the incident	Martina Corrigan: MCO
Additional/dual handler If it is practice within your team for two managers to review incidents together use this field to record the second handler	
Escalate You can use this field to note the incident has been escalated to a more senior manager within your Service/Division- select the manager from this list and send an email via the Communication section to notify the manager the incident has been escalated to them.	
Date of final approval (closed date) (dd/MM/yyyy)	

Reasons for Rejection - History

No records to display.

Linked records

No Linked Records.

Coding

Datix Common Classification System (CCS)

Category	
Sub Category	
Detail	
Is this a Haemovigilance /Blood Transfusion or Labs-related Incident?	No
Is this an incident relating to confidentiality? This may include inappropriate access / disclosure, loss or theft of records etc	No

SAI / RIDDOR / NIAIC?

Click here To Help you determine whether or not an incident constitutes an SAI please refer to the Regional SAI reporting criteria by clicking here.

SAI?

Click To help you determine whether or not an incident constitutes an SAI please refer to the Regional SAI reporting criteria by clicking here.

Is this incident RIDDOR reportable?

Below are the 5 categories which qualify a RIDDOR Reportable incident (click on blue links for further definition):
1. Employee or self-employed person working on Trust premises is killed or suffers a major injury
2. A member of the public on Trust premises is killed or taken to hospital
3. An incident connected with the Trust where an employee, or self-employed person working on Trust premises, suffers an "over 3 day injury (being incapacitated to do their normal duties for more than three consecutive days (not counting the day of the accident but including weekends and rest days). Incapacitation means that the member of staff is absent or unable to do their normal work e.g. placed on lighter duties which are not part of their normal work)
4. Dangerous Occurence attributable to the work of the Trust
5. A doctor has notified you in writing that a Trust employee suffers from a reportable work-related disease

Is this a NIAIC Incident

NIAIC (Northern Ireland Adverse Incident Centre) incidents relate to medical devices. If a medical device is involved in an incident consider the list below to identify if the incident is NIAIC reportable;
- design or manufacturing problems
- inadequate servicing and maintenance
- inappropriate local modifications
- unsuitable storage and use conditions
- selection of the incorrect device for the purpose
- inappropriate management procedures
- poor user instructions or training (which may result in incorrect user practice

Investigation

Investigator

Date started (dd/MM/yyyy)

Actual Impact/Harm: Moderate: MOD

This has been populated by the reporter. To be quality assured by the investigating manager.

Risk grading

Click here

When the incident has a Severity (actualimpact/harm, grading of insignificant to moderate, you need to plot on the matrix oppositethe Potential impact/harm. Deciding what are the chances of the incidenthappening againunder similar circumstances. (Likelihod) and multiply that by the potential impact if it were to reoccur (consequence) The overall risk grading for the event will be determined by plotting: consequence multiplied by likelihood = risk grading. Refer to impact table here:

	Consequence				
Likelihood of recurrence	Insignificant	Minor	Moderate	Major	Catastrophic
Almost certain (Expected to occur daily)	○	○	○	○	○
Likely (Expected to occur weekly)	○	○	○	○	○
Possible (Expected to occur monthly)	○	○	○	○	○
Unlikely (Expected to occur annually)	○	○	○	○	○
Rare (NOT expected to occur for years)	○	○	○	○	○

Grade:

Action taken on review

Enter here any actions you have taken as a result of the incident occurring; e.g. communicating with staff / update care plan / review risk assessment (corrective and preventative action)

Action Plan Required?

A formal action plan is required for all Moderate to Catstrophic incidents. If you tick yes an "Action plan" section will appear below. Use this to create your action plan.

Action Plan

No actions.

Lessons learned

Lessons learned

If you think there are any lessons from an incident which could be shared with other teams please record here. If not please type "none".

Date investigation completed (dd/MM/yyyy)

Was any equipment involved in the incident? No

Notepad

Notes

Use this section to record any efforts you have made as part of your investigation e.g. phonecalls / requested patient / client's chart / awaiting staff to return from sick leave. This will inform Governance staff who will be monitoring timescales for the completion of investigations etc, and reduce the amount of phone calls/emails to you requesting same information

Communication

Recipients

Message

Message history

Date/Time	Sender	Recipient	Body of Message
No messages			

Medication details

Stage

Prescriber Name

Medication error

Medication involved

If multiple medications involved enter the primary medication affecting the incident, and record the others in the description

Correct medication

Form administered

Correct form

Dose and strength involved

Correct dose

Route involved

Correct route

Falls Information
Please Quality Assure all information as part of your investigation

Did the fall occur in Hospital or Community Setting?

Specific Location of Fall

Exact location of Fall

Please describe in free-text exactly where the fall occurred

Injury Suspected?

Harm?

Buzzer / bell available within reach before fall?

Floor surface

Footwear suitable?

Walking aid in use / reach?

Mental State

First fall this admission or repeat?

Days since admission

Was the patient receiving medication which may affect the risk of falling?

Family informed of fall?

Outcome of Bedrails Assessment

Equipment details

Product type

Brand name

Serial no

Description of device

Current location

CE marking?

Description of defect

Model/size

Documents added

No documents.

People Affected

ID	Title	Forenames	Surname	Type	Current approval status
Personal Informatio		Patient 92		Patient/Client/Service User	Unapproved

Employees

No Employees

Other Contacts

No Other Contacts

Personal information redacted by USI

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1

1. ORGANISATION: SHSCT	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:** Irrelevant redacted by the USI
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: S Irrelevant redacted by the USI	**4. DATE OF INCIDENT/ EVENT: 17 July 2018**
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: No	**6. IF 'YES' TO 5. PLEASE PROVDE DETAILS:**

7. DATE OF SEA MEETING / INCIDENT DEBRIEF: 07 August 2019

8. SUMMARY OF EVENT:

Patient 92 was referred to Craigavon Area Hospital Emergency Department on 2 November 2017 by her GP for a productive cough, lethargy, sweats and back pain for 2 months. Patie nt 92 was admitted to the ward and treated for a urinary tract infection (UTI) and poor diabetic control. Patie nt 92 was discharged home the following day with a plan for an outpatient renal tract ultrasound scan (USS). Patie nt 92 had her USS on 16 November 2017 which reported further investigation was required to exclude renal malignancy.

Patie nt 92 had a follow up CT renal abdominal scan on the 28 November 2017. The CT scan reported that appearances most likely represented areas of renal inflammation, and likely infected renal cysts with probable abscess formation and that the appearances were not typical for underlying malignancy (cancer).

Patie nt 92 was contacted and advised to attend CAH ED for treatment of same. Patie nt 92 attended CAH ED and was admitted to the ward for treatment of an infected renal cyst. Prior to her discharge a follow up outpatient urology review appointment was arranged for 6 weeks and a repeat CT renal abdominal scan in 3 months' time.

Patie nt 92 never received a follow up urology outpatient review appointment. Patie nt 92 had a repeat CT scan on 13 March 2018 which reported a solid nodule suspicious of renal cell carcinoma. There was no follow up following CT report.

Patie nt 92 attended her GP on the 10 July 2018 complaining of right sided abdominal pain. Patie nt 92's GP noted the overlooked CT report and immediately forwarded a red flag urology referral to Craigavon Area Hospital.

SECTION 2

9. SEA FACILITATOR / LEAD OFFICER: Dr D Gormley, Consultant Physician	**10. TEAM MEMBERS PRESENT:** Ms W Clayton, Head of Service Mrs K Robinson, Booking & Contact Centre Manager Mrs C Connolly, Clinical Governance Manager

11. SERVICE USER DETAILS:
H&C Personal Information redacted by the USI

12. WHAT HAPPENED?

Patient 92 is a Personal Information redacted by the USI female who was referred by her GP to Craigavon Area Hospital Emergency Department (CAH) (ED) on 2 November 2017. Patient 92's presenting complaint was a productive cough, lethargy, sweats and a 2 month history of back pain. Patient 92 complained of chest tightness at times, and was noted to have a high temperature with a CRP of 100 (a blood test to check for inflammation). Patient 92 was reviewed by Dr 1 and was transferred to the ward for treatment of a urinary tract infection (UTI) and poor diabetic management. Patient 92 was treated with antibiotic Trimethoprim and discharged home later the same day with a plan for an abdominal and renal tract ultrasound scan (USS) to be carried out as an outpatient on the 16 November 2017.

On the 16 November 2017 Patient 92 attended CAH X-ray department for an ultrasound scan of the abdomen and renal tract. The report concluded a '*solid mass measuring 2.5cm at the upper pole of the left kidney required further investigation and to exclude renal malignancy'*. A urology review and CT imaging was advised.

On the 23 November 2017 Patient 92 was added to the cancer tracker system following her recent ultrasound result on 16 November 2017. Patient 92 was offered an outpatient urology appointment for 4 December 2017 at 09:00.

On the 28 November 2017 Patient 92 attended CAH X-ray department for a CT renal and abdomen scan. The CT report concluded the following:

"*Two areas of altered enhancement within the left kidney as described with surrounding inflammatory change. Appearances are most likely to represent areas of renal inflammation likely infected renal cysts with probable abscess formation. Appearances are not typical for underlying malignancy.*
*In absence of significant left-sided hydro nephrosis (swelling of the kidney) the areas of calcification within the pelvis are unlikely to represent ureteric calcification (stones) and likely to represent phelboliths (*calcification within a vein*). A clinical correlation is advised and follow up ultrasound following appropriate treatment is advised."*

On the 29 November 2017 Patient 92 was contacted at home by Dr 2 with regards to the CT scan result and advised Patient 92 to attend CAH ED and that she would be under the care of the urology team. Patient 92 was admitted to the gynaecology ward under the care of Dr 3 and treated with IV Gentamicin for an infected renal cyst. Patient 92 complained of an ongoing chronic cough during her admission and it was noted that her GP was already investigating. A recent chest x-ray taken on 2 November 2017 was reviewed which showed no acute suspicious lung abnormality. Patient 92 was discharged on 7 December 2017 on oral antibiotics with a plan for follow up at Dr 3's outpatient clinic in 6 weeks and a CT renal scan for 3 months' time.

Due to lengthy waiting lists Patient 92 never received a review appointment at Dr 3's outpatient urology clinic.

On the 13 March 2018 Patient 92 attended CAH X-ray department for a CT renal with contrast. The CT scan was reported on 20 March 2018. Result below:

"Routine multi plane imaging of the kidneys.
No evidence of renal or ureteric calculi (stones). The right kidney is normal. The 4.9 cm cystic area with surrounding inflammation and posterior aspect of the left kidney has resolved. There is very minimal residual soft tissue change. The 2.6 cm enhancing nodule in the left mid-pole is unchanged and more keeping in keeping with the solid nodule rather than an abscess. No localised lymphadenopathy (inflammation/swelling). No free fluid in the upper abdomen. The pancreas and liver

appear unremarkable. The lung bases are clear. No focal bony abnormality".

Conclusion:
"The abscess has resolved. The solid nodule is suspicious for a Renal cell carcinoma."

On 20 March 2018 the Radiology Department forwarded an email to Dr 3, secretary 1 and secretary 2 for follow up of the CT report.

On the 7 July 2018 Patient 92 contacted the General Practitioner Out Of Hours (GP OOH). Patient 92's presenting complaint was abdominal pain which had increased. Patient 92 was advised to attend CAH ED as there was no doctor in the GP OOH Craigavon base.

On the 10 July 2018 Patient 92 attended CAH ED and was reviewed by Dr 4. It was noted in the ED triage notes Patient 92 had moderate right sided abdominal pain for 2 days, with no vomiting and no diarrhoea. She was treated for a urinary tract infection (UTI) and discharged home with antibiotics and referred back to her GP.

On the 17 July 2018 Patient 92 attended her GP with mild right sided pain. On examination the GP noted her abdomen was soft, with very mild tenderness on deep palpation only. Patient 92's GP accessed Patient 92's Northern Ireland electronic care record (NIECR) (a database which contains patient health information) and noted the CT scan from March 2018 which suggested a 2.5cm solid nodule suspicious for renal cell carcinoma (cancer). Patient 92's GP immediately forwarded a red flag (suspect cancer referral) urology referral to CAH.

On the 6 August Patient 92 was reviewed at the outpatient Urology clinic and was reviewed by Dr 5. Dr 5 discussed the CT scan result carried out in March 2018 and a plan was made for a Magnetic Resonance Imaging (MRI) renal and for Patient 92 to be reviewed again with the result.

On the 17 August 2018 Patient 92 attended CAH for a MRI. The report concluded:

CONCLUSION: "No subtraction imaging. 2.3 cm left renal tumour. There are no features to allow reliable categorisation but some increased T2 signal change suggests it may represent a clear cell carcinoma."

On the 30 August Patient 92 was discussed at the urology Multi -Disciplinary Meeting (MDM). A plan was made to review Patient 92 at urology outpatients and discuss a biopsy.

On the 25 September Patient 92 had a CT chest. The conclusion was no metastatic disease within the thorax.

On the 4 October 2018 Patient 92's case was discussed at urology MDM. It was agreed Patient 92 was suitable for all treatment options and to proceed with a partial nephrectomy in CAH.

On 15 October 2018 Patient 92 was admitted to CAH for partial laparoscopic nephrectomy (partial kidney removed) for a 2.8cm renal mass. It was reported Patient 92 recovered well on the ward with no complications. Patient 92 was deemed medically fit for discharge home on 19 October 2018 with a plan for urology MDM review and histopathology.

Histopathology reported the following :

Histological examination shows a circumscribed and predominantly encapsulated tumour demonstrating features in keeping with papillary renal cell carcinoma, type I.

13. Why did it happen?

As part of the review process the chair of the review met with Patient 92 to discuss treatment and care prior to Patient 92's partial nephrectomy. Patient 92 advised that when she attended CAH with symptoms she felt staff did not listen to her concerns. Patient 92 believed her symptoms were more than a UTI and warranted further investigation at the time of presentation and not at a later date.

The review team reviewed Patient 92's first CAH ED attendance on 3 November 2017. The Review Team concluded treatment and care provided in CAH ED and on the ward was appropriate given Patient 92's presenting symptoms and the plan for an outpatient ultrasound scan was considered appropriate. The Review Team acknowledges Patient 92 had her ultrasound scan 13 days post discharge. This was considered by the Review Team an appropriate time frame for follow up.

The Review Team recognise the result of the ultrasound scan was appropriately followed up the following day by Dr 2 and arrangements were made for Patient 92 to have an urgent CT abdomen and pelvis scan to exclude renal malignancy on the 28 November 2017. The report was available the following day.

The Review Team identified Patient 92 was appropriately referred on to the cancer tracker system on the 23 November but unfortunately did not attend her appointment on 4 December 2017 due to her inpatient status under the care of the Urology Team.

The review team has reviewed Patient 92's medical notes from her admission on 29 November 2017 to her discharge on the 7 December 2017, and considers treatment and care during this period was appropriate. The Review Team recognises results were appropriately followed up by doctor 2 and appropriate arrangements were made for Patient 92 to re-attend CAH ED and to be admitted under the care of the urology team. Patient 92 was admitted to the Gynecology ward under the care of doctor 3, Consultant Urologist. Patient 92 was treated for an infected renal cyst with antibiotics. Patient 92 was discharged home with antibiotics on the 7 December 2017 with a plan to be followed up at Dr 3's outpatient clinic in six weeks and a follow up CT renal scan in three months' time. The Review Team has concluded a differential diagnosis of an infected renal cyst was appropriate following the CT report on 29 November 2017 and has therefore considered treatment and care, and discharge arrangements were all appropriate at the time.

The Review Team has reviewed the Patient Administration System (PAS) and confirmed Patient 92 was added to Dr 3's urgent urology outpatient waiting list following discharge on 7 December 2017. The Review Team acknowledges there are demand and capacity issues with Urology outpatient appointments, and waiting lists are extremely lengthy (currently 3 years). The Review Team acknowledge clinics are scheduled in advance, and recognise doctor 3's clinics may not have been scheduled that far ahead. With no outpatient clinic scheduled it would have being impossible for medical staff to ascertain Patient 92 would be appointed an outpatient appointment in six weeks' time. Patient 92 was therefore added to Dr 3's urgent urology waiting list which at the time had a waiting time of 96 weeks. Conversely, the Review Team concluded had Patient 92 been reviewed six weeks post discharge the management plan may not have changed given the recent CT scan result reporting an infected renal cyst and treatment received.

On 13 March 2018 Patient 92 attended CAH X-ray department for a CT renal with contrast. The Review Team note the report was finalised on the 20 March 2018 at 14:05. The Review Team have confirmed communication was emailed to the referring Consultant Urologist Dr 3 and secretary 1 and an additional secretary 2 (secretary1 was off on leave) on the same day 20 March 2018 at 14:54.The email advised all correspondents an urgent report for Patient 92 was available on Sectra Radiology Information System (RIS). The Review Team have identified Patient 92's report was completed in a timely manner and escalated to the referring consultant immediately by the Radiology Team. The Review Team on the other hand cannot confirm Dr 3 read the report. Secretary 2 has advised the Review

Team that in incidents like this one whereby an urgent report is emailed, the secretary would print off the report and leave in the consultant's office for follow up. The Review Team therefore can neither confirm or rule out Dr 3 received the email or a paper copy of the actual report.

The Review Team acknowledge the Trust has an escalation policy for urgent/ significant or unexpected findings and although the Radiology Department did notify the referring consultant (Dr 3) that same day, the Radiology Department did not escalate Patient 92's CT report to the Cancer Tracker Team. Following discussion with the Radiology Department the review team understands that the ability to raise an alert for the Cancer Tracking Team directly is only available for reports that are done within the Southern Trust and not for outsourced reports as in this case. The Review Team note this was a missed opportunity for follow up of Patient 92's urgent CT report.

The Review Team concluded had Dr 3 acknowledged and responded to the email from the Radiology Department and had the Radiology department escalated the result to the Cancer Tracker Team Patient 92 would have received treatment for her cancer at an earlier stage. The Review team also note that the trust policy namely "Protocol for the Reporting & Communicating of Critical, Urgent & Significant Unexpected Radiological Findings" states under the appropriate section "Communicating Life Threatening Urgent or Cancer Findings to the Referrer or Cancer Tracker" that the appropriate action for secretarial teams to take is to "contact the appropriate team via phone with a confirmation email to the referrer, referrers' secretary and the reporter of the radiological examination" The Review team noted that there was no record of a direct phone call but that the confirmation email had been sent.. The Review team considers that a direct phone call provides a level of immediate assurance that the report has been brought to the attention of the referrer.

The Review Team are aware the Trust has no formal process for tracking letters or emails to ensure they have been received, acknowledged, reviewed or actioned. The Review Team recognises consultants receive numerous emails each day and this in itself presents difficulty in identifying priority correspondence. The Review Team therefore conclude the SHSCT should consider updating its current policy to ensure all correspondence relating to urgent/ significant findings are received and actioned by recipients. The Review Team also contemplate consultant secretaries should ensure the consultant has received any paper correspondence left out for them, especially when it is an urgent report needing immediate action.

Current practice regarding tests results is that the clinician who orders the test is responsible for reviewing, following up and signing off the result even if the patient is discharged. The Review Team recognise the SHSCT does not have a single formal process for following up of test results and electronic sign off and therefore conclude the SHSCT should consider developing a system and process that will enable referring consultants to manage requested test results electronically. The system should report back to the referring clinician, highlighting any urgent results and offer options for follow up and electronic sign off. The system should be capable of providing assurance that results are viewed and actioned.

The Review Team acknowledges Patient 92 attended CAH ED hospital on the Personal information redacted by USI and was reviewed by Dr 4. Patient 92 was treated for a urinary tract infection (UTI) and discharged home with antibiotics and referred back to her GP. It was only when Patient 92 attended her GP a few days later with the same complaint, was the missed CT scan report identified and appropriate action was taken by the GP via red flag referral for follow up.

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED:

The Review Team conclude there were a number of failings in the Trust's systems and processes which ultimately lead to a delay in diagnosis and treatment and care of Patient 92's cancer. Exacerbated waiting lists, no single formal processes for following up test results, and no formal process for tracking letters or emails were contributing factors. The review team concluded that treatment and care was appropriate following Patient 92's new GP referral on the [redacted] which highlighted Patient 92's overlooked CT report.

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?

The report will be shared with all staff involved in Patient 92's treatment and care for reflection and learning.

16. RECOMMENDATIONS (please state by whom and timescale)

1. The SHSCT to review its current processes of communicating, recording and signing off suspected cancer diagnosis by consultants. The Trust is to consider a single system and process in which results can be communicated to referring clinicians and electronically signed off by the referring consultant. The system should be capable of providing assurances that all results are being viewed and actioned.
   Actioned by: Associate Medical Directors (AMD)/ Assistant Directors (AD), Head of Service (HOS) for Medicine, Surgery, Radiology and Emergency Department.

2. Acute services should explore options for the introduction of a failsafe mechanism that could provide reassurance that reports issued to referring clinicians identifying cancer or query cancer have been action. This may require additional investment.
   Actioned by: AMD/ AD for Medicine, Surgery, Radiology and Emergency Department.

3. The Radiology department should review its policy "Protocol for the Reporting & Communicating of Critical, Urgent & Significant Unexpected Radiological Findings". The policy should consider the process for outsourced reports in relation to the alert for the Cancer Tracking Team.
   Actioned: AD/HOS for Radiology.

4. The Review Team acknowledges Urology waiting lists are extensive and this was a contributing factor in this incident. The Review Team therefore advises the Trust to consider implementing a management plan to reduce Urology waiting times.
   Actioned by: AMD/ AD /HOS for Surgery.

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

18. FURTHER REVIEW REQUIRED? No
Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)	
19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	**20.** PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY
21. REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:	
22. TERMS OF REFERENCE *(If known or submit asap)*:	

SECTION 5	
APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR	
23. NAME: Melanie McClements	**24.** DATE APPROVED: 13/11/2020
25. DESIGANTION: Director of Acute Services	

SECTION 6

26. DISTRIBUTION LIST:

Patient 92
Director of Acute Services
Clinical Director for Surgery and Elective Care
Assistant Director for Surgery and Elective Care
Head of Service for Urology
Head of Service for Radiology
The review team.
Staff involved in Patient 92's care.

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:	Irrelevant redacted by the USI	HSCB Ref Number:	S Irrelevant redacted by the USI

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**	✓	**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**	✓	**NO**		
	If **YES**, insert **date informed**: 28/10/2020				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	✓	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**	✓	**NO**	
	If **YES**, insert date informed: 14/01/21			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed (***if you select this option please also complete 'l' below***)	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2

INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*

1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**			**NO**	✓			
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**			**NO**				
	If **YES**, insert **date report shared**:							
	If **NO**, please provide details:							
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**	
	If **YES**, insert **date informed**:							
	If **NO**, please provide details:							

DATE CHECKLIST COMPLETED	**14/01/21**

[1] *Service User or their nominated representative*

Acute Action Plan

Reference:	
Submission Date for Assurance Response / Action Plan to Medical Director:	**28 June 2021**
Operational Directors	**Melanie McClements Director of Acute Services**
Leads	**Ronan Carroll Assistant Director of Acute Services SEC** **Barry Conway Assistant Director of Acute Services IMWH & Diagnostics** **Mary Burke Assistant Director of Unscheduled Care** **Mr Mark Haynes Associate Medical Director for Surgery** **Dr Shahid Tariq Associate Medical Director Cancer and Clinical Services** **Denise Newell Head of Service Radiology** **Amie Nelson Head of Service Surgery**

Action Plan

REF: Irrelevant redacted by the USI

Reference number	Recommendations	Designated responsible person	Action required	Date for completion/ timescale	Date recommendation completed with evidence
1	The SHSCT to review its current processes of communicating, recording and signing off suspected cancer diagnosis by consultants. The Trust is to consider a single system and process in which results can be communicated to referring clinicians and electronically signed off by the referring consultant. The system should be capable of providing assurances that all results are being viewed and actioned. Actioned by: Associate Medical Directors (AMD)/ Assistant Directors (AD), Head of Service (HOS) for Medicine, Surgery, Radiology and Emergency Department.	AD CCS AMD CCS	Work is ongoing to implement this process across all specialities	Reviewed on monthly basis through the monthly Governance Forum	Within Northern Ireland Electronic Care Record (NIECR) there is a sign off function available for Consultants. When a scan is requested by a consultant the radiology reports are listed for Consultants for the last six weeks to read, sign off and a there is a 'type on' function available to state what action has been taken by the Consultant.

2	Acute services should explore options for the introduction of a failsafe mechanism that could provide reassurance that reports issued to referring clinicians identifying cancer or query cancer have been action. This may require additional investment. Actioned by: AMD/ AD, Radiology and Emergency Department.	AMD/ AD for, Radiology and Emergency Department.	A safety netting process has been developed and piloted. This is currently pending decision on investment to enable this to be put in place.  Radiology Safety Net Team Proposal.docx	If agreement for funding approved this could be implemented in 3 months' time.	Pending approval of funding to implement.
3	The Radiology department should review its policy "Protocol for the Reporting & Communicating of Critical, Urgent & Significant Unexpected Radiological Findings". The policy should consider the process for outsourced reports in relation to the alert for the Cancer Tracking Team. Actioned: AD/HOS for Radiology.	AD/HOS for Radiology.		Complete	The protocol for the reporting & Communicating of Critical, Urgent & Significant Unexpected Radiological Findings was reviewed early 2021, revised and updated accordingly. The outsourced reports have been issued to all clinical teams for implementation in March 2021.

4	The Review Team acknowledges Urology waiting lists are extensive and this was a contributing factor in this incident. The Review Team therefore advises the Trust to consider implementing a management plan to reduce Urology waiting times. Actioned by: AMD/ AD /HOS for Surgery.	AMD/ AD /HOS for Surgery.	The Trust acknowledges waiting times for Urology is excessive. Reasons are multifactorial and not least the interdependence for the Urology Team working across emergency and elective services. The Trust continues to work with HSCB to avail of all opportunities to reduce all aspects of Urology waiting times including admin and clinical validation, availing of in house additionality, the Independent Sector and sending patients to other Trusts which provide Urology Services.	Ongoing	Ongoing

Southern Health and Social Care Trust
Radiology

Proposal for the Introduction of a Radiology Safety Net Team Within SHSCT

Context

The SHSCT Radiology Team produces approximately 300,000 reports annually to both primary and secondary care. While the majority of these reports require no action to be taken, there are a number of reports where a recommendation will be for further follow-up or action.

There has been concern raised within the clinical and radiology teams following a number of datix incidents and SAIs which have been directly linked to non-action of recommendations made on radiology reports and impact on clinical care for our patients as a result.

Methodology and Approach

During the pandemic, the radiology department had a number of staff who were shielding and an opportunity presented itself to set up a small project team to utilise these clinical staff to evaluate the scale of the problem.

1. Quantify the volume of reports which were reported as requiring urgent communication or where the report contained the words “follow up” in the body of the report.
2. Cross-reference these reports with hospital systems to ascertain if required action had been taken
3. Evaluate the volume of reports where no action was taken

This project team ascertained that approximately 5% of all radiology reports will need onward referral/follow-up action by the referring clinician. The analysis of reports undertaken for examinations during 2019 demonstrated that, approximately 10,500 reports contain the word follow up and approximately 4500 reports needed communicated urgently as set out in below tables.

Table 1: Overview of Total Examinations for Review Period January 2019 – December 2019

	Examinations Reviewed	No Follow ups		Late Follow ups	
Jan-Feb	498	30	6.02%	18	3.61%
Mar-Apr	465	67	14.41%	34	7.31%
May-Jun	440	47	10.68%	26	5.91%

July-Aug	421	30	7.13%	12	2.85%
Sept-Oct	448	37	8.26%	25	5.58%
Nov-Dec	466	48	10.30%	31	6.65%
Total	**2738**	**259**	**9.46%**	**146**	**5.33%**

NB This sample was only in respect of lung nodules follow up

Table 2: Overview of Urgent Report Communicated for Review Period January – March 2021

	Examinations Reviewed	No Action Taken	
Jan	191	24	12.5%
Feb	192	11	5.7%
Mar	185	21	11.3%
Total	568	56	9.8%

Findings

The analysis undertaken by the project team demonstrated that of the 3306 examinations reviewed, 315 were not actioned (9.5%) and a further 146 were delayed in action being taken (4%).

Proposal

The SHSCT radiology service would like to develop a Radiology Safety Net Team to review and track patients reports, initially focusing on those reports that contain the word “follow up” or that have been communicated urgently to the clinical teams to ensure that appropriate action and follow-up has occurred for the patient. We would also like to augment the communication function of this team further by ensuring that all cancelled in-patient examinations following justification

process is fed back to the clinical teams timely in order that onward management of the patient is not delayed. The current process unfortunately has led to delays with this communication.

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The Radiology Safety Net Team would provide a clinical review by the radiographers to assess if a follow up or appropriate action had occurred and where there has been a failure in process, necessary action will be taken to ensure the patient is followed-up appropriately by timely communication with the clinical teams involved. The admin and clerical staff will support the radiographers in the communication process, tracking of patients to ensure action has actually taken place and close of the safety net loop, including escalation where required – working much like our cancer tracking team.

Requirements

The volumes of patients falling into the categories identified for primary focus for the Radiology Safety Team (Urgent Communication and reports containing “follow-up”), as well as initial project analysis of almost 10% of reports having no action has demonstrated a need for the following staff in the team:

2 x Band 6 Radiographers

2 x Band 4 A&C Tracking Staff

This staffing level is based upon the previous preparation work in which the radiographers identified that staff would be able to review between 30 and 40 examinations per day.

Southern Health and Social Care Trust
Radiology

Radiology Safety Net Process

Clinical Member of team reviews identified patients in spreadsheet using RIS & NIECR, to ensure that appropriate follow up has been actioned by the referring clinician.

An associated RIS Flag "No Follow up Action Taken" is added by the Clinical Team member for those examinations where the referrer has failed to act.

Admin Staff identify these examinations using a dedicated dynamic worklist in the RIS. These examinations require the letter "SHSCT no follow up" to be printed from the RIS. Once printed the associated flag should be removed, and the date letter printed added into the excel spreadsheet

Letters saved as a PDF and emailed to the Referring Clinician and their secretary.

The Clinician is given 4 weeks in order for action to be taken.

The Clinical member of staff filters spreadsheet on letter print date to recheck if required action has occurred on these examinations

Did Referring Clinician take action

YES

Spreadsheet is updated by Clinical Team member to record action has been taken

NO

Examination details are sent via email to the Clinical Director of Speciality

If no response from Clinical Director then details sent to Assistant Medical Director/ Medical Director

Datix

David Cardwell

SHSCT GOVERNANCE TEAM (IR2) Form -NEW June 2018

Incident Details
ID & Status

Incident Reference ID	Personal information redacted by USI
Submitted time (hh:mm)	12:53

Incident IR1 details

Notification email ID number	[redacted]
Incident date (dd/MM/yyyy)	06/01/2016
Time (hh:mm)	09:30
Does this incident involve a patient under the age of 16 within a Hospital setting (inpatient or ED)	
Does this incident involve a Staff Member?	
Description Enter facts, not opinions. Do not enter names of people	Patient Patient 10 HCN Personal Information DOB Personal Information Had a CT scan 24/6/2014 as follow-up of bowel cancer. CT showed an abnormal renal cyst with two further cysts in the right kidney. US performed 24/7/2014 showed solid elements within the anterior lower pole cyst and recommended an MRI to further evaluate. MRI performed 2/9/2014 reported 'Comparison to previous ultrasound dated 24/07/2014 and CT dated 24/06/2014. There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney, measuring 8.7 cm x 5.3 cm in size. This lesion is T2 hyperintense, T1 hypointense, and demonstrates no abnormal enhancement. The MR appearances are consistent with a cyst'. No comment made on the MRI report regarding the anterior lower pole which had concerning features on CT and US. Had a further CT on 29/10/2014 as follow-up for breats cancer which again reported '3.6 cm exophytic complex cyst is seen in the lower pole of the left kidney anteriorly containing solid and cystic component. Simple cyst seen in the upper pole measuring 7 cm. Left kidney show no focal lesion...Complex cyst right kidney.(previously investigations noted)' Patient 10 was referred to the urology department on 29/10/2014 for assessment and advice regarding the cyst with the MRI report. referral was marked as routine byt the |GP (on basis that MRI had reported a benign cyst). Referral was not triaged on receipt. Patient 10 sent OP appointment for [redacted]. Consultant had noted in clinic preperation that the MRI report had not commented on the abnormal cyst and requested a further review by a consultant radiologist who reported the abnormal cyst as a likely cystic renal cancer. Patient 10 was seen in clinic on [redacted] the sequence of events was outlined and surgical treatment of a suspected cystic renal cancer recommended after completion of up to date staging with a further CT scan.
Action taken Enter action taken at the time of the incident	There has been a resultant 18 month delay in OP review and recommendation of treatment for a suspected kidney cancer. Patient and husband fully informed of events and shown reports and imaging.

Learning Initial	
Reported (dd/MM/yyyy)	06/01/2016
Reporter's full name	Mark Haynes
Reporter's SHSCT Email Address	
Opened date (dd/MM/yyyy)	06/01/2016
Were restrictive practices used?	
Name This will auto-populate with the patient/client's name if the person-affected details have been entered for this incident.	Patient 10

Location of Incident

Site	Craigavon Area Hospital
Loc (Type)	Outpatient Clinic
Loc (Exact)	Urology Clinic
Directorate	Acute Services
Division	Surgery and Elective Care
Service Area	General Surgery
Speciality / Team	Urology Surgery

Staff initially notified upon submission

Recipient Name	Recipient E-mail	Date/Time	Contact ID	Telephone Number	Job Title
Contact ID Personal Informati not found	Eamon.Mackle(Personal information redacted by USI	06/01/2016 12:54:12	Personal Information redacted by the USI		
Smyth, Paul MR	Personal information redacted by USI	06/01/2016 12:54:11			Head of Unscheduled Care
Trouton, Heather		06/01/2016 12:54:11			Assistant Director of Acute Services
Connolly, Connie		06/01/2016 12:54:11			Acting Acute Governance Co-Ordinator

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Below are the 5 categories which qualify a RIDDOR Reportable incident (click on blue links for further definition):
1. Employee or self-employed person working on Trust premises is killed or suffers a major injury
2. A member of the public on Trust premises is killed or taken to hospital
3. An incident connected with the Trust where an employee, or self-employed person working on Trust premises, suffers an "over 3 day injury (being incapacitated to do their normal duties for more than three consecutive days (not counting the day of the accident but including weekends and rest days). Incapacitation means that the member of staff is absent or unable to do their normal work e.g. placed on lighter duties which are not part of their normal work)
4. Dangerous Occurence attributable to the work of the Trust
5. A doctor has notified you in writing that a Trust employee suffers from a reportable work-related disease

Is this a NIAIC Incident NIAIC (Northern Ireland Adverse Incident Centre) incidents relate to medical devices. If a medical device is involved in an incident consider the list below to identify if the incident is NIAIC reportable; - design or manufacturing problems - inadequate servicing and maintenance - inappropriate local modifications - unsuitable storage and use conditions - selection of the incorrect device for the purpose - inappropriate management procedures - poor user instructions or training (which may result in incorrect user practice	No

Investigation

Investigator	Connie Connolly Martina Corrigan
Date started (dd/MM/yyyy)	06/01/2016
Actual Impact/Harm This has been populated by the reporter. To be quality assured by the investigating manager.	Major

Risk grading

Click here
When the incident has a Severity (actualimpact/harm, grading of insignificant to moderate, you need to plot on the matrix oppositethe Potential impact/harm. Deciding what are the chances of the incidenthappening againunder similar circumstances. (Likelihod) and multiply that by the potential impact if it were to reoccur (consequence) The overall risk grading for the event will be determined by plotting: consequence multiplied by likelihood = risk grading. Refer to impact table here:

	Consequence				
Likelihood of recurrence	Insignificant	Minor	Moderate	Major	Catastrophic
Almost certain (Expected to occur daily)	○	○	○	○	○
Likely (Expected to occur weekly)	○	○	○	○	○
Possible (Expected to occur monthly)	○	○	○	◉	○
Unlikely (Expected to occur annually)	○	○	○	○	○
Rare (NOT expected to occur for years)	○	○	○	○	○

Grade: High Risk

Action taken on review Enter here any actions you have taken as a result of the incident occurring; e.g. communicating with staff / update care plan / review risk assessment (corrective and preventative action)	060116cc- this has been moved to review. Streamed to SEC for management but willalso involve Radiology and functional support. Communication emails sent to ATTICs,Functional Services and Patie re same and access provided. To be prepared for SAI screening. HOS aware.230316cc- this has been screened and validated as a Level 2 SAI. Will be managed via SAI process. Screening documentation attached. Closed to await SAI
Action Plan Required? A formal action plan is required for all Moderate to Catstrophic incidents. If you tick yes an "Action plan" section will appear below. Use this to create your action plan.	No

Action Plan

No actions.

Lessons learned

Lessons learned If you think there are any lessons from an incident which could be shared with other teams please record here. If not please type "none".	await

Route involved

Correct route

Falls Information
Please Quality Assure all information as part of your investigation

Did the fall occur in Hospital or Community Setting?

Specific Location of Fall

Exact location of Fall

Please describe in free-text exactly where the fall occurred

Injury Suspected?

Harm?

Buzzer / bell available within reach before fall?

Floor surface

Footwear suitable?

Walking aid in use / reach?

Mental State

First fall this admission or repeat?

Days since admission

Was the patient receiving medication which may affect the risk of falling?

Family informed of fall?

Outcome of Bedrails Assessment

Pressure Ulcers

Was this incident in respect of a Pressure Ulcer?

Equipment details

Product type

Brand name

Serial no

Description of device

Current location

CE marking?

Description of defect

Model/size

Documents added

Created	Type	Description	ID
29/01/2018		TOR 23.11.16	48188
29/01/2018		Report	48189
29/01/2018		Letter advising report complete 24.3.17	48190
29/01/2018		Cover letter and report issued registered post 31.3.17	48191
29/01/2018		Confirmation of meeting on 10.4.17 posted 31.3.17	48192
29/01/2018		Notes of meeting approved	48193
29/01/2018		Report closed 26.1.18	48194
23/03/2016	Form	SAI notification	34255
23/03/2016	Form	SAI screening form	34254
06/01/2016	PDF Document	US report 240714	32778
06/01/2016	E_Mail	Email correspondance with radiology consultant	32779
06/01/2016	PDF Document	CT report 291014	32775
06/01/2016	PDF Document	CT report 240614	32776
06/01/2016	PDF Document	MRI report 260914	32777

People Affected

ID	Title	Forenames	Surname	Type	Current approval status
Personal Information		Patient 10		Patient/Client/Service User	Unapproved

Employees

ID	Title	Forenames	Surname	Type	Current approval status
Personal Information	Mr	Mark	Haynes	Staff - Medical and Dental	Unapproved

Other Contacts

No Other Contacts

Received from Mr Mark Haynes on 16/09/22. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Root Cause Analysis report on the review of a Serious Adverse Incident

Organisation's Unique Case Identifier: ID [Irrelevant redacted by the USI]

Date of Incident/Event: 6 January 2016

HSCB Unique Case Identifier: S[Irrelevant redacted by the USI]

Service User Details:

D.O.B: [Personal Information redacted by the USI] Gender: F Age: [Personal Information redacted by the USI]

Responsible Lead Officer: Connie Connolly

Designation: Lead Nurse Acute Governance

Report Author: Review Team

Date report signed off: 15 March 2017

Date submitted to HSCB: 16 March 2017

Southern Health and Social Care Trust

1.0 EXECUTIVE SUMMARY

Patient 10 is a Personal Information redacted by the USI lady with a past medical history of colon cancer in 2010 and breast cancer in 2013.

While Patient 10 was under review and follow up by the Breast Surgeons in June 2014, a Computer Tomography Scan (CT Scan) of the abdomen and pelvis was arranged and this was performed on 24 June 2014. This CT scan reported a number of cysts in both kidneys. On the right side, there was a large upper pole cyst, a small lower pole cyst and a cyst on the anterior aspect of the right lower pole which had increased in size with increased complexity from scans completed in 2010. An Ultra Sound Scan (USS) of kidneys was recommended and this was completed on 24 July 2014. A Magnetic Resonance Image with contrast (MRI) was advised, and this was done on 26 September 2014. The MRI report did not comment on the anterior cyst about which concerns were raised, but did confirm a cyst with no abnormal enhancement.

On the basis of this incomplete MRI report, Patient 10's GP made routine referral to the Urology Team in Craigavon Area Hospital (CAH). This GP letter was received by the CAH Booking Centre on 29 October 2014. This letter was given to the Urology Surgeon of the week on 30 September 2014 to triage. There is no evidence that this GP referral letter was triaged or returned to the Booking Centre for processing. As a result of triage omission, Patient 10 was managed as a 'New Routine' patient as per the Trust's process in place at the time and waited until Personal Information redacted by USI to be seen by a Consultant Urologist. A wait of 64 weeks.

Patient 10 was diagnosed with a probable cystic renal tumour. Surgery was scheduled for 25 January 2106 but this was postponed due to the recurrence of breast cancer at this same time. Right partial nephrectomy was performed on Personal Information redacted by USI

The Review Panel agree that there are 3 main contributing factors which directly impacted Patient 10's delay in diagnosis. The first contributing factor was the content of the MRI report dated on the 29 September 2014. The wording of the report appears truncated and does not reference the main clinical focus, which was anterior cyst on the right kidney. The Reporter did not grade the cyst. As a result, the Breast Surgeon Dr 3 and the GP Dr 5 reading this report, did not appreciate there was growth in size of the right cyst. This was a significant missed opportunity for clinicians to expedite Patient 10's referral to Urology.

Secondly, following the CT of chest and abdomen of Personal Information redacted by USI which noted a complex right renal cyst, the letter to Patient 10 from Dr 3 did not include this information and the result did not trigger a referral to Urology. Again this represents a missed opportunity to expedite Patient 10's care.

The third contributory factor is that Patient 10's GP referral letter was not triaged by the Urology Consultant on call. The Review Panel agree that review of radiology at triage is likely to have resulted in an upgrade of the referral to Red Flag in October 2014. As a result of no triage and the Trust's reliance on the routine category assigned by the GP to the referral, Patient 10 waited 16 months to be assessed by the Urology Team and diagnosed with renal carcinoma.

Southern Health and Social Care Trust

2.0 THE REVIEW TEAM

Mr Anthony Glackin Consultant Urologist

Dr Aaron Milligan Consultant Radiologist

Christine Rankin Acting Booking Manager

Connie Connolly Lead Nurse Acute Governance

3.0 SAI REVIEW TERMS OF REFERENCE

Terms of Reference for the Serious Adverse Incident Investigation are as follows:

- To carry out a review into the care provided to Patient 10 in Craigavon Area Hospital, from 24 June 2014 until 6 January 2016

- To carry out this review into the care provided to Patient 10 using the National Patient Safety Agency Root Cause Analysis methodology

- To use a multidisciplinary team approach to the review

- To provide an agreed chronology based on documented evidence and staff accounts of events

- To identify the key contributory factors which may have had an influence or contributed to Patient 10's delay in treatment.

- To ensure that recommendations are made in line with evidence based practice.

- To set out the findings, recommendations, actions and lessons learnt in an anonymous report

- To adhere to the principles of confidentiality throughout the review.

- To report the findings and recommendations of the review through the Director of Acute Services SHSCT, to the relatives of Patient 10 and the staff associated with Patient 10's management

Southern Health and Social Care Trust

4.0 REVIEW METHODOLOGY

- To carry out a review into the care provided to Patient 10 within the SHSCT from 8 April 2014 until 1 March 2016. Records electronic records available on the Patient Administration System (PAS), Northern Ireland Electronic Care Record (NIECR) the Northern Ireland Picture Archiving and Communication System (NIPACS) will be examined in conjunction with all Clinical and Nursing documentation.

- To carry out this review into the care provided to Patient 10 using the National Patient Safety Agency Root Cause Analysis methodology

- To use a multidisciplinary team approach to the review

- To provide an agreed chronology based on documented evidence and staff accounts of events

- To identify the key contributory factors which may have had an influence or contributed to the timing of Patient 10's clinical management.

- To ensure that recommendations are made in line with evidence based practice. Accompanying appendices to the report will provide evidence of recent researched-based management of

- To set out the findings, recommendations, actions and lessons learnt in an anonymous report

- To adhere to the principles of confidentiality throughout the review.

- To report the findings and recommendations of the review through the Director of Acute Services SHSCT, to Patient 10 and the staff associated with Patient 10's care

This list is not exhaustive

Southern Health and Social Care Trust

5.0 DESCRIPTION OF INCIDENT/CASE

On [redacted] Patient 10 had CT of Abdomen and Pelvis (CTAP) and was reported on 3 December 2010 which stated simple renal cyst particular on the right.

On 13 January 2013 CTAP reported by Dr 10. Bosniak type 1 cyst right kidney noted.

On [redacted], Patient 10 had a CTAP with contrast as ordered by Dr 1. Dr 7's report in relation to the CTAP was issued on 7 July 2014 and reported multiple and bilateral simple cysts. A cyst arising from the anterior aspect of the right lower pole demonstrates subtle layering with high density in its medial aspect. The cyst appears minimally larger. A cyst in the anterior aspect of the right lower pole appears minimally larger and complex with high density in its medial aspect. Localised ultrasound was recommended to ensure no soft tissue component.

On 24 July 2014, Dr 1 ordered at ultrasound of the urinary tract. Dr 2's report on 30 July 2014 concluded a right lower pole complex renal cyst? Solid component. Advised MRI with intravenous (i/v) contrast to determine if the solid component enhances.

On [redacted], Patient 10 seen by Dr 3 who ordered CT of Chest and Abdomen (CT CA).

On [redacted] Patient 10 had a MRI of renal tract completed at the request of, or requested on behalf of, Dr 1. Dr 2's report on 29 September 2014 compared the previous [redacted] There is a large well-defined ovoid cystic mass, arising from the upper pole cortex of the right kidney. Appearances are consistent with cyst.

On [redacted] Patient 10 attended for CT CA with i/v contrast. Dr 4 compared CT on [redacted] reported simple cyst seen in the upper pole. Complex cyst right kidney. On the same day, a routine GP referral was received in CAH Booking Centre from Dr 5 requesting assessment and advice in relation to the MRI findings reported on 26/09/14 re: large renal cyst and mentioning a history of bowel cancer and breast cancer.

On 7 November 2014, letter sent to Patient 10 from Dr 3 informing her of unchanged findings of CT CA done on [redacted] and that there would be further Surgical Outpatient review. The CT reported a complex right renal cyst. This finding was not included in the letter Patient 10 and was not escalated to either Urology or Radiology for further opinion.

On [redacted], Patient 10 was seen by Dr 8 in Urology Outpatients in response to GP referral on 29 October 2014. The MRI images were reviewed by Dr 8 in advance of the consultation. Dr 8 noted that the MRI report from 29/09/14 did not comment on the anterior lower pole of the right kidney. Dr 8 spoke with Dr 7 regarding the findings. In retrospect, Dr 7 reported the complex cyst on the right kidney had internal solid nodules with one area showing some enhancement with contrast. This raised the possibility of cystic renal cancer. Surgery arranged for [redacted].

On [redacted], Patient 10 was reviewed by Dr 3 with an enlarged left axillary noted

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on CT. A malignant node in the let axilla with invasive lobular carcinoma was confirmed.

Personal information redacted by USI 6 Patient 10 had a left axillary node clearance. Staging and further management of Patient 10 's renal cyst has been postponed.

Patient 10 is recovering from a laparoscopic partial nephrectomy for confirmed papillary renal cell carcinoma which was performed on Personal information redacted by USI .

6.0 FINDINGS

The Specialists within the Review Panel individually assessed each of Patient 10 's radiological investigations in the timeframe between 24 June 2014 and 6 January 2016. The report by Dr 2 on 29 September 2014 references the findings of the USS and CT images done in June and July 2014. The Panel agree that when Dr 2 mentioned the earlier findings within the Personal information redacted by USI MRI report, it implied that the ovoid cystic mass noted had been seen and had been investigated. The inclusions of previous imaging findings are ambiguous. The consensus is that Dr 2's reported findings in relation to Patient 10 's MRI of both kidneys were misleading and were inappropriately condensed. The Panel contribute this to human error. This error was the primary contributing factor to the delayed recognition of a potential renal cancer and its subsequent management.

The Review Panel agree that the absence of a complete right kidney assessment, and the wording of the MRI report, made it extremely difficult for clinicians to detect the missing clinical detail. This provides sufficient rationale to why Patient 10 was not referred to Urology for immediate assessment by Dr 3 or the GP Dr 5. The CT chest and abdomen of Personal information redacted by USI reported a complex right renal cyst. This important finding was not included in the letter by Dr 3 to Patient 10 on 7 November 2014 and was not referred on for urological opinion. This represents a missed opportunity to expedite investigation of a reported abnormality.

The Review Panel reviewed the GP Referral Letter management for Patient 10 in October 2014 .In summary; Dr 6 was the Consultant Urologist on-call on 30 October 2014 and was responsible for the triage of the GP letters for that week. Patient 10 was one of eight letters for Triage.

The Triage form for 30 October 2014 was not returned to medical records for processing. After 10 working days, the booking centre e-mailed Dr 6's personal secretary seeking management advice for the 8 patients with outstanding triage. After no reply, a second email request was sent to Dr 6's personal secretary seeking management advice which was outstanding from 30 October 2014. At this point the informal booking centre default process for patients with no referral triage was initiated. The informal default triage management process was introduced in May 2014 to ensure the GP's referrals were allocated to a 'waiting list' in the event that the triage was not returned. A default management process was formally circulated on 6 November 2015.The pathway for GP referrals without triage is for the medical records team to accept the GP Grading, code the patient specialty as 'General Urology' and allocate the next available new patient appointment. The length of time until

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6.0 FINDINGS

assessment is solely dependent on the Urology waiting time- which was a minimum of 42 weeks in 2014. The default management process provides an explanation to why Patient 10 's 'Routine' referral letter was not upgraded and why Patient 10 was not seen by the Urology Team until Personal information redacted by USI .

Patient 10 is now recovering from a laparoscopic excision of a papillary renal carcinoma which was done on Personal information redacted by USI . This procedure was superseded by breast surgery in 2016 for breast lobular carcinoma on Personal information redacted by USI . It had been agreed by the Oncology and Urology teams that the breast histology was priority and treatment proceeded in advance of renal surgery.

Relevant members of the Review Team completed a 'look-back' exercise in relation to the remaining 7 other GP letters to establish the patient management and outcome. The Panel can confirm that the other 7 patients have been seen by the Urology Team on or before 26 January 2016, and have not been known to have been exposed to significant harm.

7.0 CONCLUSIONS

The MRI report by Dr 2 on 29 September 2014 as previously discussed, was misleading and was inappropriately condensed. The quality of the information resulted in the evolving right renal cyst being overlooked by Drs 3 and Dr 5.

The SHSCT Radiology Team continuously review and audit the quality and accuracy of their reporting. On this occasion, the MRI report irregularities were not detected until viewed by a Urology Consultant.

All available evidence suggests that Dr 6 did not triage Patient 10 's GP referral letter on the week ending 30 October 2014. The default triage management process was initiated which resulted in Patient 10 waiting 64 weeks for Urological assessment.

The Review Panel agree that in relation to Patient 10 , the opportunity to upgrade the referral to red flag was lost by the omission of triage, this resulted in a 64 week delay to diagnosis of a suspicious renal mass.

While the remit of this Serious Adverse Incident (SAI) Review was to examine the factors in Patient 10 's delayed management of papillary renal cancer. The Review Panel were provided evidence that a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team.

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8.0 LESSONS LEARNED

There will always be an element of human error in the interpretation and reporting of radiological imaging.

Triage of GP referral letters remains a key element in validating appropriate utilisation of specialist services and ensuring patient safety. Triage also serves as an opportunity for early intervention for patients at risk of malignant disease or clinical deterioration.

9.0 RECOMMENDATIONS AND ACTION PLANNING

This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with IEAP

In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP.

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10.0 DISTRIBUTION LIST

Patient 10

HSCB

SHSCT Litigation

SHSCT Medical Director

SHSCT Director of Acute Services

AMD for Surgery and Elective Care

AMD for Integrated Maternal/Women's Health and Clinical Services

AD's for Surgery and Elective Care, Integrated Maternal/Women's Health/Clinical Services and Functional Support Services

Chair of Surgical Morbidity and Mortality

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

(This checklist should be completed in full and submitted to the HSCB along with the completed SAI Review Report for all levels of SAI reviews)

Reporting Organisation SAI Ref Number:	**ID** Personal information redacted by	**HSCB Ref Number:**	**S** Personal information redacted by

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, a number of service users or if the SAI relates **only** to a HSC Child Death notification *(SAI criterion 4.2.2)* **Please select as appropriate (✓)**	**Single Service User**	x	**Multiple Service Users***		**HSC Child Death Notification only**		
	Comment: ***If multiple service users involved please indicate the number involved***						
2) Was the Service User[1] / Family / Carer informed the incident was being investigated as a SAI? **Please select as appropriate (✓)**	**YES**	x	**NO**				
	If **YES**, insert **date informed**: 6 January 2016						
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being investigated as a SAI						
	a) No contact or Next of Kin details or Unable to contact						
	b) Not applicable as this SAI is not 'patient/service user' related						
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user						
	d) Case involved suspected or actual abuse by family						
	e) Case identified as a result of review exercise						
	f) Case is environmental or infrastructure related with no harm to patient/service user						
	g) Other rationale						
	If you selected c), d), e), f) or g) above please provide further details:						

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)

3) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	x
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			x
	c) Report not shared but contents discussed (***if you select this option please also complete 'I' below***)			
	d) No contact or Next of Kin or Unable to contact			
Continued overleaf	**e)** No response to correspondence			
	f) Withdrew fully from the SAI process			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)*		
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2

INFORMING THE CORONER'S OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*				
1) Was there a Statutory Duty to notify the Coroner at the time of death? **Please select as appropriate (✓)**	**YES**		**NO**	**x**
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) Following or during the review of the SAI was there a Statutory Duty to notify the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	**x**
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
3) If you have selected 'YES' to any of the above **'1' or '2'** has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	**x**
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	15 March 2017

SAI Quality Improvement Action Plan SAI [redacted] Patient 10

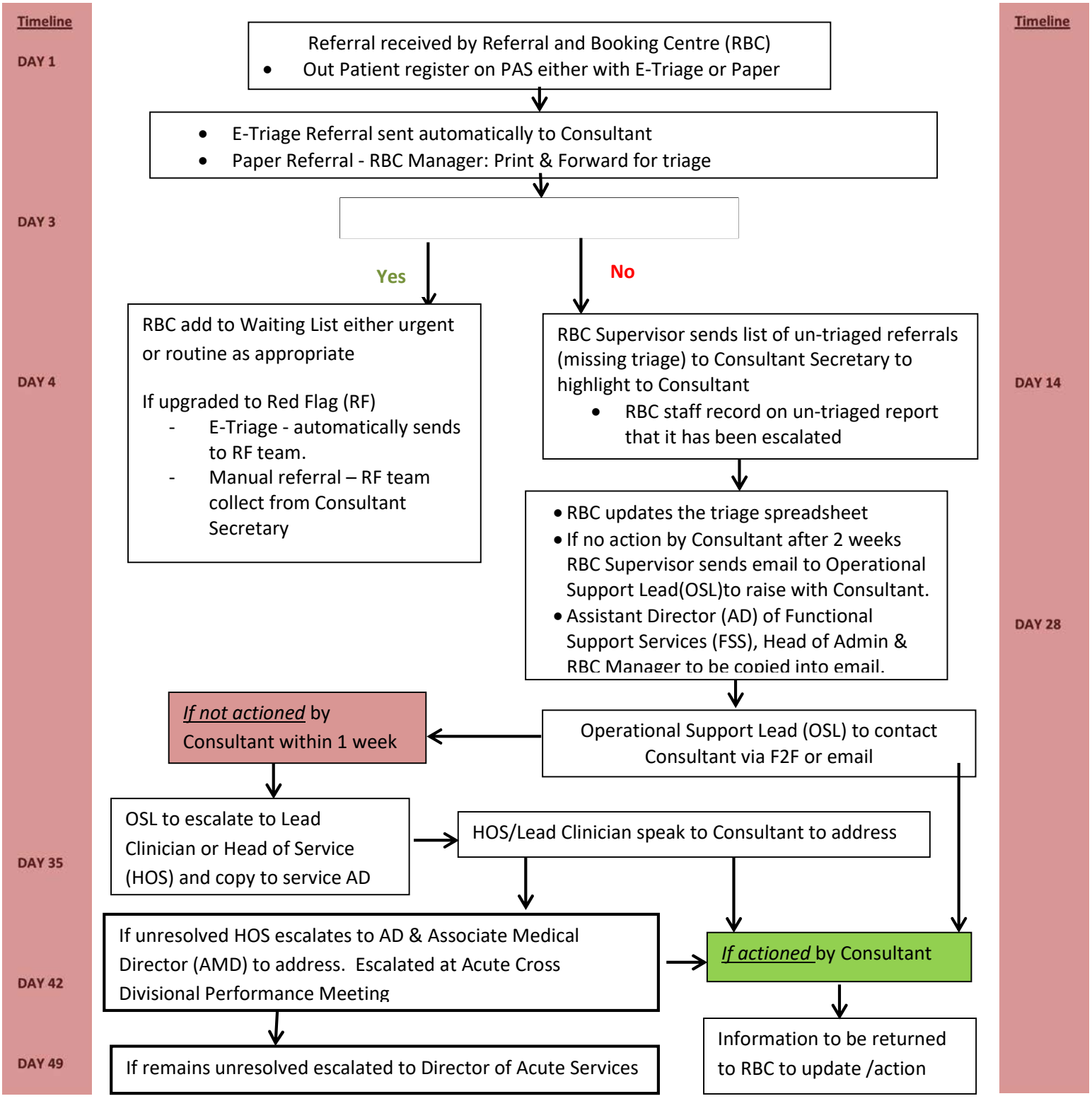
Reference number	Recommendations	Designated responsible person	Action required	Date for completion/ timescale	Date recommendation completed with evidence
1	This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with IEAP	AD Functional Services/ AD SEC	Operational escalation policy devised	March 2019	See below: TRIAGE PROCESS Dec 2020.DOCX
2	In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP.	HOS for Urology	Move the Urology Service to ETriage	March 2017	The introduction of ETriage on 27/3/17 has increased the visibility of the triage process and the implementation of robust escalation protocols throughout the management structure to include clinical management teams. Patients are no longer added to a waiting list until they have been triaged by the consultant.

TRIAGE PROCESS

- **Red Flag referrals should be returned from Triage within 24hrs**
- **Urgent referrals should be returned from Triage within 72hrs**
- **Routine referrals should be returned from Triage within week.**

PURPOSE OF TRIAGE

- Consultant triage is to confirm that the speciality is appropriate and the clinical urgency is appropriate.
- It directs the referral to an appropriate service within the speciality (e.g. to vascular surgeons etc.)
- It allows the Consultant to request any investigations which the patient will require prior to outpatient attendance
- The Consultant can return referrals with advice and no outpatient attendance where appropriate.



Note: This process will incur a minimum of 7 weeks in total if referral is un-triaged within the target times which means that if the referral is upgraded to Red Flag it is in excess of 14 day Red Flag turnaround.
It is the responsibility of the Consultant to ensure Triage is done within the appropriate timescales detailed above.

NICE National Institute for Health and Care Excellence

NICE guideline

Suspected cancer: recognition and referral

NICE guideline

Published: 23 June 2015

www.nice.org.uk/guidance/ng12

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline replaces CG27.

This guideline partially replaces CG122.

This guideline is the basis of QS96, QS124, QS130 and QS203.

This guideline should be read in conjunction with QS155.

Overview

This guideline covers identifying children, young people and adults with symptoms that could be caused by cancer. It outlines appropriate investigations in primary care, and selection of people to refer for a specialist opinion. It aims to help people understand what to expect if they have symptoms that may suggest cancer.

We have used the terms 'men' and 'women' in some recommendations on gender-related cancers, but they also apply to people who have changed or are in the process of changing gender, and who retain the relevant organs.

Who is it for?

- Healthcare professionals
- People involved in clinical governance in both primary and secondary care
- People with suspected cancer and their families and/or carers.

Introduction

Safeguarding children

Remember that child maltreatment:

- is common
- can present anywhere
- may co-exist with other health problems, including suspected cancer.

See NICE's guideline on child maltreatment for clinical features that may be associated with maltreatment.

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations (although this may not apply to recommendations made before 2009; see the section on recommendation wording in guideline updates below). It also has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity) and safeguarding.

How the guideline is organised

The recommendations in this guideline have been organised into 3 separate sections to help healthcare professionals find the relevant information easily. The recommendations for investigation and referral organised by site of suspected cancer are also presented in tables of recommendations organised by symptoms and investigation findings. Either section should be used in conjunction with the recommendations on patient support, safety netting and the diagnostic process.

Recommendation wording in guideline updates

NICE began using standard wording to denote the strength of recommendations in guidelines that

started development after January 2009. It does not apply to any recommendations ending [2005] (see update information for details about how recommendations are labelled). In particular, for recommendations labelled [2005] the word 'consider' may not necessarily be used to denote the strength of the recommendation.

Recommendations organised by site of cancer

Use this guideline to guide referrals. If still uncertain about whether a referral is needed, consider contacting a specialist (see the recommendations on the diagnostic process). Consider a review for people with any symptom associated with increased cancer risk who do not meet the criteria for referral or investigative action (see the recommendations on safety netting).

1.1 Lung and pleural cancers

Lung cancer

1.1.1 Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for lung cancer if they:

- have chest X-ray findings that suggest lung cancer or
- are aged 40 and over with unexplained haemoptysis. [2015]

1.1.2 Offer an urgent chest X-ray (to be done within 2 weeks) to assess for lung cancer in people aged 40 and over if they have 2 or more of the following unexplained symptoms, or if they have ever smoked and have 1 or more of the following unexplained symptoms:

- cough
- fatigue
- shortness of breath
- chest pain
- weight loss
- appetite loss. [2015]

1.1.3 Consider an urgent chest X-ray (to be done within 2 weeks) to assess for lung cancer in people aged 40 and over with any of the following:

- persistent or recurrent chest infection
- finger clubbing
- supraclavicular lymphadenopathy or persistent cervical lymphadenopathy
- chest signs consistent with lung cancer
- thrombocytosis. [2015]

Mesothelioma

1.1.4 Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for mesothelioma if they have chest X-ray findings that suggest mesothelioma. [2015]

1.1.5 Offer an urgent chest X-ray (to be done within 2 weeks) to assess for mesothelioma in people aged 40 and over, if:

- they have 2 or more of the following unexplained symptoms, or
- they have 1 or more of the following unexplained symptoms and have ever smoked, or
- they have 1 or more of the following unexplained symptoms and have been exposed to asbestos:
  - cough
  - fatigue
  - shortness of breath
  - chest pain
  - weight loss
  - appetite loss. [2015]

1.1.6 Consider an urgent chest X-ray (to be done within 2 weeks) to assess for mesothelioma in people aged 40 and over with either:

- finger clubbing or

- chest signs compatible with pleural disease. [2015]

1.2 Upper gastrointestinal tract cancers

Oesophageal cancer

1.2.1 Offer urgent, direct access upper gastrointestinal endoscopy (to be done within 2 weeks) to assess for oesophageal cancer in people:

- with dysphagia or
- aged 55 and over with weight loss and any of the following:
  - upper abdominal pain
  - reflux
  - dyspepsia. [2015]

1.2.2 Consider non-urgent direct access upper gastrointestinal endoscopy to assess for oesophageal cancer in people with haematemesis. [2015]

1.2.3 Consider non-urgent direct access upper gastrointestinal endoscopy to assess for oesophageal cancer in people aged 55 or over with:

- treatment-resistant dyspepsia or
- upper abdominal pain with low haemoglobin levels or
- raised platelet count with any of the following:
  - nausea
  - vomiting
  - weight loss
  - reflux
  - dyspepsia
  - upper abdominal pain, or

- nausea or vomiting with any of the following:
  - weight loss
  - reflux
  - dyspepsia
  - upper abdominal pain. [2015]

Pancreatic cancer

1.2.4 Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for pancreatic cancer if they are aged 40 and over and have jaundice. [2015]

1.2.5 Consider an urgent direct access CT scan (to be done within 2 weeks), or an urgent ultrasound scan if CT is not available, to assess for pancreatic cancer in people aged 60 and over with weight loss and any of the following:

- diarrhoea
- back pain
- abdominal pain
- nausea
- vomiting
- constipation
- new-onset diabetes. [2015]

Stomach cancer

1.2.6 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people with an upper abdominal mass consistent with stomach cancer. [2015]

1.2.7 Offer urgent direct access upper gastrointestinal endoscopy (to be done within 2 weeks) to assess for stomach cancer in people:

- with dysphagia or
- aged 55 and over with weight loss and any of the following:
  - upper abdominal pain
  - reflux
  - dyspepsia. [2015]

1.2.8 Consider non-urgent direct access upper gastrointestinal endoscopy to assess for stomach cancer in people with haematemesis. [2015]

1.2.9 Consider non-urgent direct access upper gastrointestinal endoscopy to assess for stomach cancer in people aged 55 or over with:

- treatment-resistant dyspepsia or
- upper abdominal pain with low haemoglobin levels or
- raised platelet count with any of the following:
  - nausea
  - vomiting
  - weight loss
  - reflux
  - dyspepsia
  - upper abdominal pain, or
- nausea or vomiting with any of the following:
  - weight loss
  - reflux
  - dyspepsia
  - upper abdominal pain. [2015]

Gall bladder cancer

1.2.10 Consider an urgent direct access ultrasound scan (to be done within 2 weeks) to assess for gall bladder cancer in people with an upper abdominal mass consistent with an enlarged gall bladder. [2015]

Liver cancer

1.2.11 Consider an urgent direct access ultrasound scan (to be done within 2 weeks) to assess for liver cancer in people with an upper abdominal mass consistent with an enlarged liver. [2015]

1.3 Lower gastrointestinal tract cancers

Colorectal cancer

1.3.1 Refer adults using a suspected cancer pathway referral (for an appointment within 2 weeks) for colorectal cancer if:

- they are aged 40 and over with unexplained weight loss and abdominal pain or
- they are aged 50 and over with unexplained rectal bleeding or
- they are aged 60 and over with:
  - iron-deficiency anaemia or
  - changes in their bowel habit, or
- tests show occult blood in their faeces. [2015]

1.3.2 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for colorectal cancer in adults with a rectal or abdominal mass. [2015]

1.3.3 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for colorectal cancer in adults aged under 50 with rectal bleeding and any of the following unexplained symptoms or findings:

- abdominal pain
- change in bowel habit

- weight loss
- iron-deficiency anaemia. [2015]

1.3.4 Offer testing with quantitative faecal immunochemical tests (see the NICE diagnostics guidance on quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care) to assess for colorectal cancer in adults without rectal bleeding who:

- are aged 50 and over with unexplained:
  - abdominal pain or
  - weight loss, or
- are aged under 60 with:
  - changes in their bowel habit or
  - iron-deficiency anaemia, or
- are aged 60 and over and have anaemia even in the absence of iron deficiency. [2021]

Anal cancer

1.3.5 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for anal cancer in people with an unexplained anal mass or unexplained anal ulceration. [2015]

1.4 Breast cancer

1.4.1 Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for breast cancer if they are:

- aged 30 and over and have an unexplained breast lump with or without pain or
- aged 50 and over with any of the following symptoms in one nipple only:
  - discharge
  - retraction
- other changes of concern. [2015]

1.4.2 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for breast cancer in people:

- with skin changes that suggest breast cancer or
- aged 30 and over with an unexplained lump in the axilla. [2015]

1.4.3 Consider non-urgent referral in people aged under 30 with an unexplained breast lump with or without pain. See also recommendations 1.16.2 and 1.16.3 for information about seeking specialist advice. [2015]

1.5 Gynaecological cancers

Ovarian cancer

The recommendations in this section have been incorporated from NICE's guideline on ovarian cancer and have not been updated. The recommendations for ovarian cancer apply to women aged 18 and over.

1.5.1 Make an urgent referral to a gynaecological cancer service if physical examination identifies ascites and/or a pelvic or abdominal mass (which is not obviously uterine fibroids). [2011, amended 2020]

1.5.2 Carry out tests in primary care (see recommendations 1.5.6 to 1.5.9) if a woman (especially if aged 50 or over) reports having any of the following symptoms on a persistent or frequent basis – particularly more than 12 times per month:

- persistent abdominal distension (women often refer to this as 'bloating')
- feeling full (early satiety) and/or loss of appetite
- pelvic or abdominal pain
- increased urinary urgency and/or frequency. [2011]

1.5.3 Consider carrying out tests in primary care (see recommendations 1.5.6 to 1.5.9) if a woman reports unexplained weight loss, fatigue or changes in bowel habit. [2011]

1.5.4 Advise any woman who is not suspected of having ovarian cancer to return to

her GP if her symptoms become more frequent and/or persistent. [2011]

1.5.5 Carry out appropriate tests for ovarian cancer (see recommendations 1.5.6 to 1.5.9) in any woman aged 50 or over who has experienced symptoms within the last 12 months that suggest irritable bowel syndrome (IBS), because IBS rarely presents for the first time in women of this age. (See NICE's guideline on irritable bowel syndrome in adults). [2011]

1.5.6 Measure serum CA125 in primary care in women with symptoms that suggest ovarian cancer (see recommendations 1.5.1 to 1.5.5). [2011]

1.5.7 If serum CA125 is 35 IU/ml or greater, arrange an ultrasound scan of the abdomen and pelvis. [2011]

1.5.8 If the ultrasound suggests ovarian cancer, make an urgent referral to a gynaecological cancer service. [2011, amended 2020]

1.5.9 For any woman who has normal serum CA125 (less than 35 IU/ml), or CA125 of 35 IU/ml or greater but a normal ultrasound:

- assess her carefully for other clinical causes of her symptoms and investigate if appropriate
- if no other clinical cause is apparent, advise her to return to her GP if her symptoms become more frequent and/or persistent. [2011]

Endometrial cancer

1.5.10 Refer women using a suspected cancer pathway referral (for an appointment within 2 weeks) for endometrial cancer if they are aged 55 and over with post-menopausal bleeding (unexplained vaginal bleeding more than 12 months after menstruation has stopped because of the menopause). [2015]

1.5.11 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for endometrial cancer in women aged under 55 with post-menopausal bleeding. [2015]

1.5.12 Consider a direct access ultrasound scan to assess for endometrial cancer in women aged 55 and over with:

- unexplained symptoms of vaginal discharge who:
  - are presenting with these symptoms for the first time or
  - have thrombocytosis or
  - report haematuria, or
- visible haematuria and:
  - low haemoglobin levels or
  - thrombocytosis, or
  - high blood glucose levels. [2015]

Cervical cancer

1.5.13 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for women if, on examination, the appearance of their cervix is consistent with cervical cancer. [2015]

Vulval cancer

1.5.14 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for vulval cancer in women with an unexplained vulval lump, ulceration or bleeding. [2015]

Vaginal cancer

1.5.15 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for vaginal cancer in women with an unexplained palpable mass in or at the entrance to the vagina. [2015]

1.6 Urological cancers

Prostate cancer

1.6.1 Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for prostate cancer if their prostate feels malignant on digital rectal examination. [2015]

1.6.2 Consider a prostate-specific antigen (PSA) test and digital rectal examination to assess for prostate cancer in people with:

- any lower urinary tract symptoms, such as nocturia, urinary frequency, hesitancy, urgency or retention or
- erectile dysfunction or
- visible haematuria. [2015]

1.6.3 Consider referring people with possible symptoms of prostate cancer, as specified in recommendation 1.6.2, using a suspected cancer pathway referral (for an appointment within 2 weeks) for prostate cancer if their PSA levels are above the threshold for their age in table 1. Take into account the person's preferences and any comorbidities when making the decision. [2021]

Table 1 Age-specific PSA thresholds for people with possible symptoms of prostate cancer

Age (years)	Prostate-specific antigen threshold (micrograms/litre)
Below 40	Use clinical judgement
40 to 49	More than 2.5
50 to 59	More than 3.5
60 to 69	More than 4.5
70 to 79	More than 6.5
Above 79	Use clinical judgement

For a short explanation of why the committee made the 2021 recommendation and how it might affect practice, see the rationale and impact section on PSA testing for prostate cancer.

Full details of the evidence and the committee's discussion are in evidence review A: PSA testing for prostate cancer.

Bladder cancer

1.6.4 Refer people using a suspected cancer pathway referral (for an appointment

within 2 weeks) for bladder cancer if they are:

- aged 45 and over and have:
  - unexplained visible haematuria without urinary tract infection or
  - visible haematuria that persists or recurs after successful treatment of urinary tract infection, or
- aged 60 and over and have unexplained non-visible haematuria and either dysuria or a raised white cell count on a blood test. [2015]

1.6.5 Consider non-urgent referral for bladder cancer in people aged 60 and over with recurrent or persistent unexplained urinary tract infection. [2015]

Renal cancer

1.6.6 Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for renal cancer if they are aged 45 and over and have:

- unexplained visible haematuria without urinary tract infection or
- visible haematuria that persists or recurs after successful treatment of urinary tract infection. [2015]

Testicular cancer

1.6.7 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for testicular cancer in men if they have a non-painful enlargement or change in shape or texture of the testis. [2015]

1.6.8 Consider a direct access ultrasound scan for testicular cancer in men with unexplained or persistent testicular symptoms. [2015]

Penile cancer

1.6.9 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for penile cancer in men if they have:

- a penile mass or ulcerated lesion, when a sexually transmitted infection has been excluded as a cause, or

- a persistent penile lesion after treatment for a sexually transmitted infection has been completed. [2015]

1.6.10 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for penile cancer in men with unexplained or persistent symptoms affecting the foreskin or glans. [2015]

1.7 Skin cancers

Malignant melanoma of the skin

1.7.1 Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for melanoma if they have a suspicious pigmented skin lesion with a weighted 7-point checklist score of 3 or more. [2015]

Weighted 7-point checklist

Major features of the lesions (scoring 2 points each):

- change in size
- irregular shape
- irregular colour.

Minor features of the lesions (scoring 1 point each):

- largest diameter 7 mm or more
- inflammation
- oozing
- change in sensation.

1.7.2 Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) if dermoscopy suggests melanoma of the skin. [2015]

1.7.3 Consider a suspected cancer pathway referral (for an appointment within

2 weeks) for melanoma in people with a pigmented or non-pigmented skin lesion that suggests nodular melanoma. [2015]

Squamous cell carcinoma

1.7.4 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people with a skin lesion that raises the suspicion of squamous cell carcinoma. [2015]

Basal cell carcinoma

1.7.5 Consider routine referral for people if they have a skin lesion that raises the suspicion of a basal cell carcinoma. (Typical features of basal cell carcinoma include: an ulcer with a raised rolled edge; prominent fine blood vessels around a lesion; or a nodule on the skin [particularly pearly or waxy nodules].) [2015]

1.7.6 Only consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people with a skin lesion that raises the suspicion of a basal cell carcinoma if there is particular concern that a delay may have a significant impact, because of factors such as lesion site or size. [2015]

1.7.7 Follow NICE's guidance on improving outcomes for people with skin tumours including melanoma for advice on who should excise suspected basal cell carcinomas. [2015]

1.8 Head and neck cancers

Laryngeal cancer

1.8.1 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for laryngeal cancer in people aged 45 and over with:

- persistentunexplained hoarseness or
- an unexplained lump in the neck. [2015]

Oral cancer

1.8.2 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for oral cancer in people with either:

- unexplained ulceration in the oral cavity lasting for more than 3 weeks or
- a persistent and unexplained lump in the neck. [2015]

1.8.3 Consider an urgent referral (for an appointment within 2 weeks) for assessment for possible oral cancer by a dentist in people who have either:

- a lump on the lip or in the oral cavity or
- a red or red and white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia. [2015]

1.8.4 Consider a suspected cancer pathway referral by the dentist (for an appointment within 2 weeks) for oral cancer in people when assessed by a dentist as having either:

- a lump on the lip or in the oral cavity consistent with oral cancer or
- a red or red and white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia. [2015]

Thyroid cancer

1.8.5 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for thyroid cancer in people with an unexplained thyroid lump. [2015]

1.9 Brain and central nervous system cancers

Adults

1.9.1 Consider an urgent, direct access, MRI scan of the brain (or CT scan if MRI is contraindicated; to be done within 2 weeks) to assess for brain or central nervous system cancer in adults with progressive, sub-acute loss of central neurological function. [2015]

Children and young people

1.9.2 Consider a very urgent referral (for an appointment within 48 hours) for suspected brain or central nervous system cancer in children and young people with newly abnormal cerebellar or other central neurological function. [2015]

1.10 Haematological cancers

Leukaemia in adults

1.10.1 Consider a very urgent full blood count (within 48 hours) to assess for leukaemia in adults with any of the following:

- pallor
- persistent fatigue
- unexplained fever
- unexplained persistent or recurrent infection
- generalised lymphadenopathy
- unexplained bruising
- unexplained bleeding
- unexplained petechiae
- hepatosplenomegaly. [2015]

Leukaemia in children and young people

1.10.2 Refer children and young people for immediate specialist assessment for leukaemia if they have unexplained petechiae or hepatosplenomegaly. [2015]

1.10.3 Offer a very urgent full blood count (within 48 hours) to assess for leukaemia in children and young people with any of the following:

- pallor
- persistent fatigue
- unexplained fever
- unexplained persistent infection
- generalised lymphadenopathy

- persistent or unexplained bone pain
- unexplained bruising
- unexplained bleeding. [2015]

Myeloma

1.10.4 Offer a full blood count and blood tests for calcium and plasma viscosity or erythrocyte sedimentation rate to assess for myeloma in people aged 60 and over with persistent bone pain, particularly back pain, or unexplained fracture. [2015]

1.10.5 Offer very urgent protein electrophoresis and a Bence–Jones protein urine test (within 48 hours) to assess for myeloma in people aged 60 and over with hypercalcaemia or leukopenia and a presentation that is consistent with possible myeloma. [2015]

1.10.6 Consider very urgent protein electrophoresis and a Bence–Jones protein urine test (within 48 hours) to assess for myeloma if the plasma viscosity or erythrocyte sedimentation rate and presentation are consistent with possible myeloma. [2015]

1.10.7 Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) if the results of protein electrophoresis or a Bence–Jones protein urine test suggest myeloma. [2015]

Non-Hodgkin's lymphoma

Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements.

Adults

1.10.8 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for non-Hodgkin's lymphoma in adults presenting with unexplained lymphadenopathy or splenomegaly. When considering referral, take into account any associated symptoms, particularly fever, night sweats, shortness of breath, pruritus or weight loss. [2015]

Children and young people

1.10.9 Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment for non-Hodgkin's lymphoma in children and young people presenting with unexplained lymphadenopathy or splenomegaly. When considering referral, take into account any associated symptoms, particularly fever, night sweats, shortness of breath, pruritus or weight loss. [2015]

Hodgkin's lymphoma

Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements.

Adults

1.10.10 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for Hodgkin's lymphoma in adults presenting with unexplained lymphadenopathy. When considering referral, take into account any associated symptoms, particularly fever, night sweats, shortness of breath, pruritus, weight loss or alcohol-induced lymph node pain. [2015]

Children and young people

1.10.11 Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment for Hodgkin's lymphoma in children and young people presenting with unexplained lymphadenopathy. When considering referral, take into account any associated symptoms, particularly fever, night sweats, shortness of breath, pruritus or weight loss. [2015]

1.11 Sarcomas

Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements.

Bone sarcoma in adults

1.11.1 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for adults if an X-ray suggests the possibility of bone sarcoma. [2015]

Bone sarcoma in children and young people

1.11.2 Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment for children and young people if an X-ray suggests the possibility of bone sarcoma. [2015]

1.11.3 Consider a very urgent direct access X-ray (to be done within 48 hours) to assess for bone sarcoma in children and young people with unexplained bone swelling or pain. [2015]

Soft tissue sarcoma in adults

1.11.4 Consider an urgent direct access ultrasound scan (to be done within 2 weeks) to assess for soft tissue sarcoma in adults with an unexplained lump that is increasing in size. [2015]

1.11.5 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for adults if they have ultrasound scan findings that are suggestive of soft tissue sarcoma or if ultrasound findings are uncertain and clinical concern persists. [2015]

Soft tissue sarcoma in children and young people

1.11.6 Consider a very urgent direct access ultrasound scan (to be done within 48 hours) to assess for soft tissue sarcoma in children and young people with an unexplained lump that is increasing in size. [2015]

1.11.7 Consider a very urgent referral (for an appointment within 48 hours) for children and young people if they have ultrasound scan findings that are suggestive of soft tissue sarcoma or if ultrasound findings are uncertain and clinical concern persists. [2015]

1.12 Childhood cancers

NICE has published a guideline on babies, children and young people's experience of healthcare.

Neuroblastoma

1.12.1 Consider very urgent referral (for an appointment within 48 hours) for specialist

assessment for neuroblastoma in children with a palpable abdominal mass or unexplained enlarged abdominal organ. [2015]

Retinoblastoma

1.12.2 Consider urgent referral (for an appointment within 2 weeks) for ophthalmological assessment for retinoblastoma in children with an absent red reflex. If there is new-onset squint that occurs together with an absent red reflex, see the recommendation on new-onset squint with loss of red reflex in NICE's guideline on suspected neurological conditions. [2015]

Wilms' tumour

1.12.3 Consider very urgent referral (for an appointment within 48 hours) for specialist assessment for Wilms' tumour in children with any of the following:

- a palpable abdominal mass
- an unexplained enlarged abdominal organ
- unexplained visible haematuria. [2015]

1.13 Non-site-specific symptoms

Some symptoms or symptom combinations may be features of several different cancers. For some of these symptoms, the risk for each individual cancer may be low but the total risk of cancer of any type may be higher. This section includes recommendations for these symptoms.

Symptoms of concern in children and young people

1.13.1 Take into account the insight and knowledge of parents and carers when considering making a referral for suspected cancer in a child or young person. Consider referral for children if their parent or carer has persistent concern or anxiety about the child's symptoms, even if the symptoms are most likely to have a benign cause. [2015]

Symptoms of concern in adults

1.13.2 For people with unexplained weight loss, which is a symptom of several cancers including colorectal, gastro-oesophageal, lung, prostate, pancreatic and

urological cancer:

- carry out an assessment for additional symptoms, signs or findings that may help to clarify which cancer is most likely and
- offer urgent investigation or a suspected cancer pathway referral (for an appointment within 2 weeks). [2015]

1.13.3 For people with unexplained appetite loss, which is a symptom of several cancers including lung, oesophageal, stomach, colorectal, pancreatic, bladder and renal cancer:

- carry out an assessment for additional symptoms, signs or findings that may help to clarify which cancer is most likely and
- offer urgent investigation or a suspected cancer pathway referral (for an appointment within 2 weeks). [2015]

1.13.4 For people with deep vein thrombosis, which is associated with several cancers including urogenital, breast, colorectal and lung cancer:

- carry out an assessment for additional symptoms, signs or findings that may help to clarify which cancer is most likely and
- consider urgent investigation or a suspected cancer pathway referral (for an appointment within 2 weeks). [2015]

Recommendations on patient support, safety netting and the diagnostic process

Use this guideline to guide referrals. If still uncertain about whether a referral is needed, consider contacting a specialist (see the recommendations on the diagnostic process). Consider a review for people with any symptom associated with increased cancer risk who do not meet the criteria for referral or investigative action (see the recommendations on safety netting).

1.14 Patient information and support

1.14.1 Discuss with people with suspected cancer (and their carers as appropriate, taking account of the need for confidentiality) their preferences for being involved in decision-making about referral options and further investigations including their potential risks and benefits. [2015]

1.14.2 When cancer is suspected in a child, discuss the referral decision and information to be given to the child with the parents or carers (and the child if appropriate). [2015]

1.14.3 Explain to people who are being referred with suspected cancer that they are being referred to a cancer service. Reassure them, as appropriate, that most people referred will not have a diagnosis of cancer, and discuss alternative diagnoses with them. [2015]

1.14.4 Give the person information on the possible diagnosis (both benign and malignant) in accordance with their wishes for information (see also NICE's guideline on patient experience in adult NHS services). [2015]

1.14.5 The information given to people with suspected cancer and their families and/or carers should cover, among other issues:

- where the person is being referred to
- how long they will have to wait for the appointment

- how to obtain further information about the type of cancer suspected or help before the specialist appointment
- what to expect from the service the person will be attending
- what type of tests may be carried out, and what will happen during diagnostic procedures
- how long it will take to get a diagnosis or test results
- whether they can take someone with them to the appointment
- who to contact if they do not receive confirmation of an appointment
- other sources of support. [2015]

1.14.6 Provide information that is appropriate for the person in terms of language, ability and culture, recognising the potential for different cultural meanings associated with the possibility of cancer. [2015]

1.14.7 Have information available in a variety of formats on both local and national sources of information and support for people who are being referred with suspected cancer. For more information on information sharing, see the section on enabling patients to actively participate in their care in NICE's guideline on patient experience in adult NHS services. [2015]

1.14.8 Reassure people in the safety netting group (see recommendation 1.15.2) who are concerned that they may have cancer that with their current symptoms their risk of having cancer is low. [2015]

1.14.9 Explain to people who are being offered safety netting (see recommendation 1.15.2) which symptoms to look out for and when they should return for re-evaluation. It may be appropriate to provide written information. [2015]

1.14.10 When referring a person with suspected cancer to a specialist service, assess their need for continuing support while waiting for their referral appointment. This should include inviting the person to contact their healthcare professional again if they have more concerns or questions before they see a specialist. [2005]

1.14.11 If the person has additional support needs because of their personal circumstances, inform the specialist (with the person's agreement). [2005]

1.15 Safety netting

1.15.1 Ensure that the results of investigations are reviewed and acted upon appropriately, with the healthcare professional who ordered the investigation taking or explicitly passing on responsibility for this. Be aware of the possibility of false-negative results for chest X-rays and tests for occult blood in faeces. [2015]

1.15.2 Consider a review for people with any symptom that is associated with an increased risk of cancer, but who do not meet the criteria for referral or other investigative action. The review may be:

- planned within a time frame agreed with the person or
- patient-initiated if new symptoms develop, the person continues to be concerned, or their symptoms recur, persist or worsen. [2015]

1.16 The diagnostic process

1.16.1 Take part in continuing education, peer review and other activities to improve and maintain clinical consulting, reasoning and diagnostic skills, in order to identify at an early stage people who may have cancer, and to communicate the possibility of cancer to the person. [2005]

1.16.2 Discussion with a specialist (for example, by telephone or email) should be considered if there is uncertainty about the interpretation of symptoms and signs, and whether a referral is needed. This may also enable the primary healthcare professional to communicate their concerns and a sense of urgency to secondary healthcare professionals when symptoms are not classical. [2005]

1.16.3 Put in place local arrangements to ensure that letters about non-urgent referrals are assessed by the specialist, so that the person can be seen more urgently if necessary. [2005]

1.16.4 Put in place local arrangements to ensure that there is a maximum waiting period for non-urgent referrals, in accordance with national targets and local

arrangements. [2005]

1.16.5 Ensure local arrangements are in place to identify people who miss their appointments so that they can be followed up. [2005]

1.16.6 Include all appropriate information in referral correspondence, including whether the referral is urgent or non-urgent. [2005]

1.16.7 Use local referral proformas if these are in use. [2005]

1.16.8 Once the decision to refer has been made, make sure that the referral is made within 1 working day. [2005]

Recommendations organised by symptom and findings of primary care investigations

The recommendations in this section are displayed alphabetically by symptom then in order of urgency of the action needed, to make sure that the most urgent actions are not missed. Where there are several recommendations relating to the same cancer these have been grouped for ease of reference. Occasionally the same symptom may suggest more than one cancer site. In such instances the recommendations are displayed together and the GP should use their clinical judgement to decide on the most appropriate action.

Use this guideline to guide referrals. If still uncertain about whether a referral is needed, consider contacting a specialist (see the recommendations on the diagnostic process). Consider a review for people with any symptom associated with increased cancer risk who do not meet the criteria for referral or investigative action (see the recommendations on safety netting).

Abdominal symptoms

See also the section on bleeding for recommendations on rectal bleeding.

Abdominal distension

Symptom and specific features	Possible cancer	Recommendation
Abdominal distension (persistent or frequent – particularly more than 12 times per month) in women, especially if 50 and over	Ovarian	Carry out tests in primary care [1.5.2] Measure serum CA125 in primary care [1.5.6] See the section on primary care investigations for more information on tests for ovarian cancer These recommendations apply to women aged 18 and over

Abdominal examination findings

Symptoms and signs	Possible cancer	Recommendation
Ascites and/or a pelvic or abdominal mass identified by physical examination (which is not obviously uterine fibroids) in women	Ovarian	Urgent referral [1.5.1] These recommendations apply to women aged 18 and over

Abdominal, pelvic or rectal mass or enlarged abdominal organ

Symptom and specific features	Possible cancer	Recommendation
Abdominal or pelvic mass identified by physical examination (which is not obviously uterine fibroids) in women	Ovarian	Urgent referral [1.5.1] These recommendations apply to women aged 18 and over
Abdominal or rectal mass	Colorectal	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.3.2]
Splenomegaly (unexplained) in adults	Non-Hodgkin's lymphoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks). When considering referral, take into account any associated symptoms, particularly fever, night sweats, shortness of breath, pruritus or weight loss [1.10.8] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Upper abdominal massconsistent with stomach cancer	Stomach	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.2.6]

Symptom and specific features	Possible cancer	Recommendation
Upper abdominal mass consistent with an enlarged gall bladder	Gall bladder	Consider an urgent direct access ultrasound scan (to be done within 2 weeks) [1.2.10]
Upper abdominal mass consistent with an enlarged liver	Liver	Consider an urgent direct access ultrasound scan (to be done within 2 weeks) [1.2.11]
Hepatosplenomegaly	Leukaemia	Consider a very urgent full blood count (within 48 hours) [1.10.1]

Abdominal or pelvic pain

Symptom and specific features	Possible cancer	Recommendation
Abdominal pain with weight loss (unexplained), 40 and over	Colorectal	Refer adults using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.3.1]
Abdominal pain (unexplained) with rectal bleeding in adults under 50	Colorectal	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.3.3]
Abdominal pain (unexplained) without rectal bleeding, 50 and over	Colorectal	Offer testing with quantitative faecal immunochemical tests (see the NICE diagnostics guidance on quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care) [1.3.4]
Upper abdominal pain with weight loss, 55 and over	Oesophageal or stomach	Offer urgent direct access upper gastrointestinal endoscopy (to be done within 2 weeks) [1.2.1] [1.2.7]

Symptom and specific features	Possible cancer	Recommendation
Upper abdominal pain with low haemoglobin levels or raised platelet count or nausea or vomiting, 55 and over	Oesophageal or stomach	Consider non-urgent direct access upper gastrointestinal endoscopy [1.2.3] [1.2.9]
Abdominal or pelvic pain (persistent or frequent – particularly more than 12 times per month) in women, especially if 50 and over	Ovarian	Carry out tests in primary care [1.5.2] Measure serum CA125 in primary care [1.5.6] See the section on primary care investigations for more information on tests for ovarian cancer These recommendations apply to women aged 18 and over
Abdominal pain with weight loss, 60 and over	Pancreatic	Consider an urgent direct access CT scan (to be done within 2 weeks), or an urgent ultrasound scan if CT is not available [1.2.5]
Irritable bowel syndrome symptoms within the last 12 months in women 50 and over	Ovarian	Carry out appropriate tests for ovarian cancer, because irritable bowel syndrome rarely presents for the first time in women of this age [1.5.5] Measure serum CA125 in primary care [1.5.6] See the section on primary care investigations for more information on tests for ovarian cancer These recommendations apply to women aged 18 and over Also see the NICE guideline on irritable bowel syndrome in adults.

Change in bowel habit

Symptom and specific features	Possible cancer	Recommendation
Change in bowel habit (unexplained), 60 and over	Colorectal	Refer adults using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.3.1]
Change in bowel habit (unexplained) with rectal bleeding, in adults under 50	Colorectal	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.3.3]
Change in bowel habit without rectal bleeding, adults under 60	Colorectal	Offer testing with quantitative faecal immunochemical tests (see the NICE diagnostics guidance on quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care) [1.3.4]
Change in bowel habit (unexplained) in women	Ovarian	Consider carrying out tests in primary care [1.5.3] Measure serum CA125 in primary care [1.5.6] See the section on primary care investigations for information on tests for ovarian cancer These recommendations apply to women aged 18 and over
Diarrhoea or constipation with weight loss, 60 and over	Pancreatic	Consider an urgent direct access CT scan (to be done within 2 weeks), or an urgent ultrasound scan if CT is not available [1.2.5]

Symptom and specific features	Possible cancer	Recommendation
Irritable bowel syndrome symptoms within the last 12 months, in women 50 and over	Ovarian	Carry out appropriate tests for ovarian cancer, because irritable bowel syndrome rarely presents for the first time in women of this age [1.5.5] Measure serum CA125 in primary care [1.5.6] See the section on primary care investigations for more information about tests for ovarian cancer These recommendations apply to women aged 18 and over Also see the NICE guideline on irritable bowel syndrome in adults

Dyspepsia

Symptom and specific features	Possible cancer	Recommendation
Dyspepsia (treatment-resistant), 55 and over	Oesophageal or stomach	Consider non-urgent direct access upper gastrointestinal endoscopy [1.2.3] [1.2.9]
Dyspepsia Dyspepsia with weight loss, 55 and over	Oesophageal or stomach	Offer urgent direct access upper gastrointestinal endoscopy (to be done within 2 weeks) [1.2.1] [1.2.7]
Dyspepsia with raised platelet count or nausea or vomiting, 55 and over	Oesophageal or stomach	Consider non-urgent direct access upper gastrointestinal endoscopy [1.2.3] [1.2.9]

Dysphagia

Symptom and specific features	Possible cancer	Recommendation
Dysphagia	Oesophageal or stomach	Offer urgent direct access upper gastrointestinal endoscopy (to be done within 2 weeks) [1.2.1, 1.2.7]

Nausea or vomiting

Symptom and specific features	Possible cancer	Recommendation
Nausea or vomiting with weight loss, 60 and over	Pancreatic	Consider an urgent direct access CT scan (to be done within 2 weeks), or an urgent ultrasound scan if CT is not available [1.2.5]
Nausea or vomiting with raised platelet count or weight loss or reflux or dyspepsia or upper abdominal pain, 55 and over	Oesophageal or stomach	Consider non-urgent direct access upper gastrointestinal endoscopy [1.2.3] [1.2.9]

Rectal examination findings

Symptom and signs	Possible cancer	Recommendation
Prostate feels malignant on digital rectal examination, in men	Prostate	Refer men using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.6.1]
Anal mass or anal ulceration (unexplained)	Anal	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.3.5]
Rectalmass	Colorectal	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.3.2]

Reflux

Symptom and specific features	Possible cancer	Recommendation
Reflux with weight loss, 55 and over	Oesophageal or stomach	Offer urgent direct access upper gastrointestinal endoscopy (to be done within 2 weeks) [1.2.1] [1.2.7]
Reflux with raised platelet count or nausea or vomiting, 55 and over	Oesophageal or stomach	Consider non-urgent direct access upper gastrointestinal endoscopy [1.2.3] [1.2.9]

Bleeding

See also:

- the section on urological symptoms for haematuria
- the section on primary care investigations for faecal occult blood.

Bleeding, bruising or petechiae

Symptom and specific features	Possible cancer	Recommendation
Bleeding, bruising or petechiae (unexplained)	Leukaemia	Consider a very urgent full blood count (within 48 hours) [1.10.1]

Haematemesis

Symptom and specific features	Possible cancer	Recommendation
Haematemesis	Oesophageal or stomach	Consider non-urgent, direct access upper gastrointestinal endoscopy [1.2.2] [1.2.8]

Haemoptysis

Symptom and specific features	Possible cancer	Recommendation
Haemoptysis (unexplained), 40 and over	Lung	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.1.1]

Post-menopausal bleeding

Symptom and specific features	Possible cancer	Recommendation
Post-menopausal bleeding in women 55 and over	Endometrial	Refer women using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.5.10]

Symptom and specific features	Possible cancer	Recommendation
Post-menopausal bleeding in women under 55	Endometrial	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.5.11]

Post-menopausal bleeding is unexplained vaginal bleeding more than 12 months after menstruation has stopped because of the menopause.

Rectal bleeding

Symptom and specific features	Possible cancer	Recommendation
Rectal bleeding (unexplained), 50 and over	Colorectal	Refer adults using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.3.1]
Rectal bleeding with abdominal pain or change in bowel habit or weight loss or iron-deficiency anaemia in adults under 50	Colorectal	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.3.3]

Vulval bleeding

Symptom and specific features	Possible cancer	Recommendation
Vulval bleeding (unexplained) in women	Vulval	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.5.14]

Gynaecological symptoms

See also the section on bleeding for post-menopausal (vaginal) bleeding

Gynaecological examination findings

Symptom and signs	Possible cancer	Recommendation
Appearance of cervixconsistent with cervical cancer	Cervical	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.5.13]

Vaginal symptoms

Symptom and specific features	Possible cancer	Recommendation
Vaginal discharge (unexplained) either at first presentation or with thrombocytosis or with haematuria, in women 55 and over	Endometrial	Consider a direct access ultrasound scan [1.5.12]
Vaginal mass (unexplained and palpable) in or at the entrance to the vagina	Vaginal	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.5.15]

Vulval symptoms

Symptom and specific features	Possible cancer	Recommendation
Vulval bleeding (unexplained)	Vulval	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.5.14]
Vulval lump or ulceration (unexplained)	Vulval	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.5.14]

Lumps or masses

Lumps and masses

Symptom and specific features	Possible cancer	Recommendation
Anal mass (unexplained)	Anal	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.3.5]

Symptom and specific features	Possible cancer	Recommendation
Axillary lump (unexplained), 30 and over	Breast	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.4.2]
Breast lump (unexplained) with or without pain, 30 and over	Breast	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.4.1]
Breast lump (unexplained) with or without pain, under 30	Breast	Consider non-urgent referral See also recommendations 1.16.2 and 1.16.3 for information about seeking specialist advice [1.4.3]
Lip or oral cavitylump	Oral	Consider an urgent referral (for an appointment within 2 weeks) for assessment by a dentist [1.8.3] Consider a suspected cancer pathway referral by the dentist (for an appointment within 2 weeks) in people when assessed by a dentist as having a lump on the lip or in the oral cavity consistent with oral cancer [1.8.4]
Lump (unexplained) that is increasing in size in adults	Soft tissue sarcoma	Consider an urgent direct access ultrasound scan (to be done within 2 weeks) [1.11.4] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Neck lump (unexplained), 45 and over	Laryngeal	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.8.1]
Neck lump (persistent and unexplained)	Oral	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.8.2]

Symptom and specific features	Possible cancer	Recommendation
Penile mass (and sexually transmitted infection has been excluded as a cause) in men	Penile	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.6.9]
Thyroid lump (unexplained)	Thyroid	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.8.5]
Vaginal mass (unexplained and palpable) in or at the entrance to the vagina in women	Vaginal	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.5.15]
Vulval lump (unexplained) in women	Vulval	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.5.14]

See also the section on abdominal symptoms for abdominal, anal, pelvic and rectal lumps or masses.

Lymphadenopathy

Symptom and specific features	Possible cancer	Recommendation
Lymphadenopathy (unexplained) in adults	Non-Hodgkin's lymphoma or Hodgkin's lymphoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) When considering referral for Hodgkin's lymphoma, take into account any associated symptoms, particularly fever, night sweats, shortness of breath, pruritus, weight loss or alcohol-induced lymph node pain [1.10.10] When considering referral for non-Hodgkin's lymphoma, take into account any associated symptoms, particularly fever, night sweats, shortness of breath, pruritus or weight loss [1.10.8] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Lymphadenopathy (supraclavicular or persistent cervical), 40 and over	Lung	Consider an urgent chest X-ray (to be done within 2 weeks) [1.1.3]
Lymphadenopathy (generalised) in adults	Leukaemia	Consider a very urgent full blood count (within 48 hours) [1.10.1]

Oral lesions

Symptom and specific features	Possible cancer	Recommendation
Ulceration in the oral cavity (unexplained and lasting for more than 3 weeks)	Oral	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.8.2]

Symptom and specific features	Possible cancer	Recommendation
Lip or oral cavity lump	Oral	Consider an urgent referral (for an appointment within 2 weeks) for assessment by a dentist [1.8.3] Consider a suspected cancer pathway referral by the dentist (for an appointment within 2 weeks) in people when assessed by a dentist as having a lump on the lip or in the oral cavity consistent with oral cancer [1.8.4]

Neurological symptoms in adults

Neurological symptoms in adults

Symptom and specific features	Possible cancer	Recommendation
Loss of central neurological function (progressive, sub-acute) in adults	Brain or central nervous system	Consider an urgent direct access MRI scan of the brain (or CT scan if MRI is contraindicated; to be done within 2 weeks) [1.9.1]

Pain

See also the section on abdominal symptoms for abdominal or pelvic pain.

Pain

Symptom and specific features	Possible cancer	Recommendation
Alcohol-induced lymph node pain with unexplained lymphadenopathy in adults	Hodgkin's lymphoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks). When considering referral, take into account any associated symptoms [1.10.10] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Back pain with weight loss, 60 and over	Pancreatic	Consider an urgent direct access CT scan (to be done within 2 weeks), or an urgent ultrasound scan if CT is not available [1.2.5]
Back pain (persistent), 60 and over	Myeloma	Offer a full blood count and blood tests for calcium and plasma viscosity or erythrocyte sedimentation rate [1.10.4] See the section on primary care investigations for more information on tests for myeloma
Bone pain (persistent), 60 and over	Myeloma	Offer a full blood count and blood tests for calcium and plasma viscosity or erythrocyte sedimentation rate to assess for myeloma [1.10.4] See the section on primary care investigations for more information on tests for myeloma
Chest pain (unexplained), 40 and over, ever smoked	Lung or mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.2] [1.1.5]
Chest pain (unexplained), 40 and over, exposed to asbestos	Mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.5]

Symptom and specific features	Possible cancer	Recommendation
Chest pain (unexplained) with cough or fatigue or shortness of breath or weight loss or appetite loss (unexplained), 40 and over	Lung or mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.2] [1.1.5]

Respiratory symptoms

Chest infection

Symptom and specific features	Possible cancer	Recommendation
Chest infection (persistent or recurrent), 40 and over	Lung	Consider an urgent chest X-ray (to be done within 2 weeks) [1.1.3]

Chest pain

Symptom and specific features	Possible cancer	Recommendation
Chest pain (unexplained), 40 and over, ever smoked	Lung or mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.2] [1.1.5]
Chest pain (unexplained), 40 and over, exposed to asbestos	Mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.5]
Chest pain (unexplained) with cough or fatigue or shortness of breath or weight loss or appetite loss (unexplained), 40 and over	Lung or mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.2] [1.1.5]

Cough

Symptom and specific features	Possible cancer	Recommendation
Cough (unexplained), 40 and over, ever smoked	Lung or mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.2] [1.1.5]
Cough (unexplained), 40 and over, exposed to asbestos	Mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.5]
Cough (unexplained) with fatigue or shortness of breath or chest pain or weight loss or appetite loss (unexplained), 40 and over	Lung or mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.2] [1.1.5]

Hoarseness

Symptom and specific features	Possible cancer	Recommendation
Hoarseness (persistent and unexplained), 45 and over	Laryngeal	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.8.1]

Respiratory examination findings

Symptom and signs	Possible cancer	Recommendation
Chest signsconsistent with lung cancer, 40 and over	Lung	Consider an urgent chest X-ray (to be done within 2 weeks) [1.1.3]
Chest signs compatible with pleural disease, 40 and over	Mesothelioma	Consider an urgent chest X-ray (to be done within 2 weeks) [1.1.6]
Finger clubbing, 40 and over	Lung or mesothelioma	Consider an urgent chest X-ray (to be done within 2 weeks) [1.1.3] [1.1.6]

Shortness of breath

Symptom and specific features	Possible cancer	Recommendation
Shortness of breath (unexplained), 40 and over, ever smoked	Lung or mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.2] [1.1.5]
Shortness of breath (unexplained), 40 and over, and exposed to asbestos	Mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.5]
Shortness of breath with cough or fatigue or chest pain or weight loss or appetite loss (unexplained), 40 and over	Lung or mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.2] [1.1.5]
Shortness of breath with unexplained lymphadenopathy in adults	Non-Hodgkin's lymphoma or Hodgkin's lymphoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks). When considering referral, take into account any associated symptoms [1.10.8] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements

Symptom and specific features	Possible cancer	Recommendation
Shortness of breath with unexplained splenomegaly in adults	Non-Hodgkin's lymphoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks). When considering referral, take into account any associated symptoms [1.10.8] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements

Skeletal symptoms

Back pain

Symptom and specific features	Possible cancer	Recommendation
Back pain with weight loss, 60 and over	Pancreatic	Consider an urgent direct access CT scan (to be done within 2 weeks), or an urgent ultrasound scan if CT is not available [1.2.5]
Back pain (persistent), 60 and over	Myeloma	Offer a full blood count and blood tests for calcium and plasma viscosity or erythrocyte sedimentation rate [1.10.4] See the section on primary care investigations for more information on tests for myeloma

Bone pain

Symptom and specific features	Possible cancer	Recommendation
Bone pain (persistent), 60 and over	Myeloma	Offer a full blood count and blood tests for calcium and plasma viscosity or erythrocyte sedimentation rate to assess for myeloma [1.10.4] See the section on primary care investigations for more information on tests for myeloma

Fracture

Symptom and specific features	Possible cancer	Recommendation
Fracture (unexplained), 60 and over	Myeloma	Offer a full blood count and blood tests for calcium and plasma viscosity or erythrocyte sedimentation rate [1.10.4] See the section on primary care investigations for more information on tests for myeloma

Skin or surface symptoms

See also the section on lumps or masses for oral lesions.

Skin or surface symptoms

Symptoms and signs	Possible cancer	Recommendation
Anal ulceration (unexplained)	Anal	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.3.5]
Bruising (unexplained) in adults	Leukaemia	Consider a very urgent full blood count (within 48 hours) [1.10.1]
Nipple changes of concern (in one nipple only) including discharge and retraction, 50 and over	Breast	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.4.1]
Oral cavity red or red and white patchconsistent with erythroplakia or erythroleukoplakia	Oral	Consider urgent referral (for an appointment within 2 weeks) for assessment by a dentist [1.8.3] Consider a suspected cancer pathway referral by the dentist (for an appointment within 2 weeks) for people when assessed by a dentist as having a red or red and white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia [1.8.4]
Pallor	Leukaemia	Consider a very urgent full blood count (within 48 hours) [1.10.1]

Symptoms and signs	Possible cancer	Recommendation
Penile lesion (ulcerated and sexually transmitted infection has been excluded, or persistent after treatment for a sexually transmitted infection has been completed) in men	Penile	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.6.9]
Penile mass (and sexually transmitted infection has been excluded as a cause) in men	Penile	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.6.9]
Penile symptomsaffecting the foreskin or glans (unexplained or persistent) in men	Penile	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.6.10]
Petechiae (unexplained) in adults	Leukaemia	Consider a very urgent full blood count (within 48 hours) [1.10.1]
Pruritus with unexplained splenomegaly in adults	Non-Hodgkin's lymphoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks). When considering referral, take into account any associated symptoms [1.10.8] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements

Symptoms and signs	Possible cancer	Recommendation
Pruritus with unexplained lymphadenopathy in adults	Hodgkin's lymphoma or non-Hodgkin's lymphoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks). When considering referral, take into account any associated symptoms [1.10.10] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Skin changes that suggest breast cancer	Breast	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.4.2]
Skin lesion (pigmented and suspicious) with a weighted 7-point checklist score of 3 or more	Melanoma	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.7.1]
Skin lesion (pigmented or non-pigmented) that suggests nodular melanoma	Melanoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.7.3]
Skin lesion that raises the suspicion of a squamous cell carcinoma	Squamous cell carcinoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.7.4]

Symptoms and signs	Possible cancer	Recommendation
Skin lesion that raises the suspicion of a basal cell carcinoma	Basal cell carcinoma	Consider routine referral [1.7.5] Only consider a suspected cancer pathway referral (for an appointment within 2 weeks) if there is particular concern that a delay may have a significant impact, because of factors such as lesion site or size [1.7.6] Typical features of basal cell carcinoma include: an ulcer with a raised rolled edge; prominent fine blood vessels around a lesion; or a nodule on the skin (particularly pearly or waxy nodules)
Vulval lump or ulceration (unexplained) in women	Vulval	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.5.14]

Urological symptoms

Dysuria

Symptom and specific features	Possible cancer	Recommendation
Dysuria with unexplained non-visible haematuria, 60 and over	Bladder	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.6.4]

Erectile dysfunction

Symptom and specific features	Possible cancer	Recommendation
Erectile dysfunction in men	Prostate	Consider a prostate-specific antigen (PSA) test and digital rectal examination [1.6.2] See the section on primary care investigations for more information on PSA tests and digital rectal examination

Haematuria

Symptom and specific features	Possible cancer	Recommendation
Haematuria (visible and unexplained) either without urinary tract infection or that persists or recurs after successful treatment of urinary tract infection, 45 and over	Bladder or renal	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.6.4] [1.6.6]
Haematuria (non-visible and unexplained) with dysuria or raised white cell count on a blood test, 60 and over	Bladder	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.6.4]
Haematuria (visible) with low haemoglobin levels or thrombocytosis or high blood glucose levels or unexplained vaginal discharge in women 55 and over	Endometrial	Consider a direct access ultrasound scan [1.5.12]
Haematuria (visible) in men	Prostate	Consider a prostate-specific antigen (PSA) test and digital rectal examination [1.6.2] See the section on primary care investigations for more information on PSA tests and digital rectal examination

Testicular symptoms

Symptom and specific features	Possible cancer	Recommendation
Testis enlargement or change in shape or texture (non-painful) in men	Testicular	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.6.7]
Testicular symptoms (unexplained or persistent) in men	Testicular	Consider a direct access ultrasound scan [1.6.8]

Other urinary tract symptoms

Symptom and specific features	Possible cancer	Recommendation
Urinary tract infection (unexplained and recurrent or persistent), 60 and over	Bladder	Consider non-urgent referral for bladder cancer in people aged 60 and over with recurrent or persistent unexplained urinary tract infection [1.6.5]
Lower urinary tract symptoms, such as nocturia, urinary frequency, hesitancy, urgency or retention in men	Prostate	Consider a prostate-specific antigen (PSA) test and digital rectal examination [1.6.2] See the section on primary care investigations for more information on PSA tests and digital rectal examination
Urinary urgency or frequency (increased and persistent or frequent – particularly more than 12 times per month) in women, especially if 50 and over	Ovarian	Carry out tests in primary care [1.5.2] Measure serum CA125 in primary care [1.5.6] See the section on primary care investigations for information on tests for ovarian cancer These recommendations apply to women aged 18 and over

Non-specific features of cancer

Appetite loss or early satiety

Symptom and specific features	Possible cancer	Recommendation
Appetite loss (unexplained)	Several, including lung, oesophageal, stomach, colorectal, pancreatic, bladder or renal	Carry out an assessment for additional symptoms, signs or findings that may help to clarify which cancer is most likely Offer urgent investigation or a suspected cancer pathway referral (for an appointment within 2 weeks) [1.13.3]

Symptom and specific features	Possible cancer	Recommendation
Appetite loss (unexplained), 40 and over, ever smoked	Lung or mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.2] [1.1.5]
Appetite loss (unexplained), 40 and over, exposed to asbestos	Mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.5]
Appetite loss (unexplained) with cough or fatigue or shortness of breath or chest pain or weight loss (unexplained), 40 and over	Lung or mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.2] [1.1.5]
Appetite loss or early satiety (persistent or frequent – particularly more than 12 times per month) in women, especially if 50 and over	Ovarian	Carry out tests in primary care [1.5.2] Measure serum CA125 in primary care [1.5.6] See the section on primary care investigations for information on tests for ovarian cancer These recommendations apply to women aged 18 and over

Deep vein thrombosis

Symptom and specific features	Possible cancer	Recommendation
Deep vein thrombosis	Several, including urogenital, breast, colorectal and lung	Carry out an assessment for additional symptoms, signs or findings that may help to clarify which cancer is most likely Consider urgent investigation or a suspected cancer pathway referral (for an appointment within 2 weeks) [1.13.4]

Diabetes

Symptom and specific features	Possible cancer	Recommendation
Diabetes (new onset) with weight loss, 60 and over	Pancreatic	Consider an urgent direct access CT scan (to be done within 2 weeks), or urgent ultrasound scan if CT is not available [1.2.5]

Fatigue

Symptom and specific features	Possible cancer	Recommendation
Fatigue (unexplained), 40 and over, ever smoked	Lung or mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.2] [1.1.5]
Fatigue (unexplained), 40 and over, exposed to asbestos	Mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.5]
Fatigue with cough or shortness of breath or chest pain or weight loss or appetite loss (unexplained), 40 and over	Lung or mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.2] [1.1.5]
Fatigue (persistent) in adults	Leukaemia	Consider a very urgent full blood count (within 48 hours) [1.10.1]
Fatigue (unexplained) in women	Ovarian	Carry out tests in primary care [1.5.2] Measure serum CA125 in primary care [1.5.6] See the section on primary care investigations for information on tests for ovarian cancer These recommendations apply to women aged 18 and over

Fever

Symptom and specific features	Possible cancer	Recommendation
Fever (unexplained)	Leukaemia	Consider a very urgent full blood count (within 48 hours) [1.10.1]
Fever with unexplained splenomegaly in adults	Non-Hodgkin's lymphoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks). When considering referral, take into account any associated symptoms [1.10.8] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Fever with unexplained lymphadenopathy in adults	Hodgkin's lymphoma or non-Hodgkin's lymphoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks). When considering referral, take into account any associated symptoms [1.10.10] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements

See also the section on respiratory symptoms for chest infection.

Infection

Symptom and specific features	Possible cancer	Recommendation
Infection (unexplained and persistent or recurrent) in adults	Leukaemia	Consider a very urgent full blood count (within 48 hours) [1.10.1]

Night sweats

Symptom and specific features	Possible cancer	Recommendation
Night sweats with unexplained splenomegaly in adults	Non-Hodgkin's lymphoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks). When considering referral, take into account any associated symptoms [1.10.8] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Night sweats with unexplained lymphadenopathy in adults	Hodgkin's lymphoma or Non-Hodgkin's lymphoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks). When considering referral, take into account any associated symptoms [1.10.10] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements

Pallor

Symptom and specific features	Possible cancer	Recommendation
Pallor	Leukaemia	Consider a very urgent full blood count (within 48 hours) [1.10.1]

Pruritus

Symptom and specific features	Possible cancer	Recommendation
Pruritus with unexplained splenomegaly in adults	Non-Hodgkin's lymphoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks). When considering referral, take into account any associated symptoms [1.10.8] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Pruritus with unexplained lymphadenopathy in adults	Hodgkin's lymphoma or non-Hodgkin's lymphoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks). When considering referral, take into account any associated symptoms [1.10.10] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements

Weight loss

Symptom and specific features	Possible cancer	Recommendation
Weight loss (unexplained)	Several, including colorectal, gastro-oesophageal, lung, prostate, pancreatic or urological cancer	Carry out an assessment for additional symptoms, signs or findings that may help to clarify which cancer is most likely Offer urgent investigation or a suspected cancer pathway referral (for an appointment within 2 weeks) [1.13.2]
Weight loss (unexplained) with abdominal pain, 40 and over	Colorectal	Refer adults using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.3.1]

Symptom and specific features	Possible cancer	Recommendation
Weight loss (unexplained) with rectal bleeding in adults under 50	Colorectal	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.3.3]
Weight loss (unexplained) without rectal bleeding, 50 and over	Colorectal	Offer testing with quantitative faecal immunochemical tests (see the NICE diagnostics guidance on quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care) [1.3.4]
Weight loss (unexplained), 40 and over, ever smoked	Lung or mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.2] [1.1.5]
Weight loss (unexplained), 40 and over, exposed to asbestos	Mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.5]
Weight loss with cough or fatigue or shortness of breath or chest pain or appetite loss (unexplained), 40 and over, never smoked	Lung or mesothelioma	Offer an urgent chest X-ray (to be done within 2 weeks) [1.1.2] [1.1.5]
Weight loss with unexplained splenomegaly in adults	Non-Hodgkin's lymphoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks). When considering referral, take into account any associated symptoms [1.10.8] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements

Symptom and specific features	Possible cancer	Recommendation
Weight loss with unexplained lymphadenopathy in adults	Hodgkin's lymphoma or non-Hodgkin's lymphoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks). When considering referral, take into account any associated symptoms [1.10.8] [1.10.10] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Weight loss with upper abdominal pain or reflux or dyspepsia, 55 and over	Oesophageal or stomach	Offer urgent direct access upper gastrointestinal endoscopy (to be done within 2 weeks) [1.2.1] [1.2.7]
Weight loss (unexplained) in women	Ovarian	Consider carrying out tests in primary care [1.5.3] Measure serum CA125 in primary care [1.5.6] See the section on primary care investigations for information on tests for ovarian cancer These recommendations apply to women aged 18 and over
Weight loss with diarrhoea or back pain or abdominal pain or nausea or vomiting or constipation or new-onset diabetes, 60 and over	Pancreatic	Consider an urgent direct access CT scan (to be done within 2 weeks), or an urgent ultrasound scan if CT is not available [1.2.5]
Weight loss with raised platelet count or nausea or vomiting, 55 and over	Oesophageal or stomach	Consider non-urgent direct access upper gastrointestinal endoscopy [1.2.3] [1.2.9]

Primary care investigations

Blood test findings

Investigation findings and specific features	Possible cancer	Recommendation
Anaemia (iron-deficiency), 60 and over	Colorectal	Refer adults using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.3.1]
Anaemia (iron-deficiency, unexplained) with rectal bleeding in adults under 50	Colorectal	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.3.3]
Anaemia (iron deficiency) without rectal bleeding, adults under 60	Colorectal	Offer testing with quantitative faecal immunochemical tests (see the NICE diagnostics guidance on quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care) [1.3.4]
Anaemia (non-iron-deficiency), without rectal bleeding, 60 and over	Colorectal	Offer testing with quantitative faecal immunochemical tests (see the NICE diagnostics guidance on quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care) [1.3.4]
Blood glucose levels high with visible haematuria in women 55 and over	Endometrial	Consider a direct access ultrasound scan [1.5.12]
Diabetes (new-onset) with weight loss, 60 and over	Pancreatic	Consider an urgent direct access CT scan (to be done within 2 weeks), or an urgent ultrasound scan if CT is not available [1.2.5]
Haemoglobin levels low with visible haematuria in women 55 and over	Endometrial	Consider a direct access ultrasound scan [1.5.12]
Haemoglobin levels low with upper abdominal pain, 55 and over	Oesophageal or stomach	Consider non-urgent direct access upper gastrointestinal endoscopy [1.2.3] [1.2.9]

Investigation findings and specific features	Possible cancer	Recommendation
Hypercalcaemia or leukopenia and presentation consistent with possible myeloma, 60 and over	Myeloma	Offer very urgent protein electrophoresis and a Bence–Jones protein urine test (within 48 hours) [1.10.5]
Plasma viscosity or erythrocyte sedimentation rate and presentation consistent with possible myeloma	Myeloma	Consider very urgent protein electrophoresis and a Bence–Jones protein urine test (within 48 hours) [1.10.6]
Platelet count raised with nausea or vomiting or weight loss or reflux or dyspepsia or upper abdominal pain, 55 and over	Oesophageal or stomach	Consider non-urgent direct access upper gastrointestinal endoscopy [1.2.3] [1.2.9]
Prostate-specific antigenlevels above the age-specific threshold in table 1 plus lower urinary tract symptoms such as nocturia, urinary frequency, hesitancy, urgency or retention or erectile dysfunction or visible haematuria	Prostate	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.6.3]
Protein electrophoresis suggests myeloma	Myeloma	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.10.7]

Investigation findings and specific features	Possible cancer	Recommendation
Serum CA125 results	Ovarian	If serum CA125 is 35 IU/ml or greater, arrange an ultrasound scan of the abdomen and pelvis [1.5.7] Normal serum CA125 (less than 35 IU/ml), or CA125 of 35 IU/ml or greater but a normal ultrasound: assess her carefully for other clinical causes of her symptoms and investigate if appropriate if no other clinical cause is apparent, advise her to return to her GP if her symptoms become more frequent and/or persistent. [1.5.9] These recommendations apply to women aged 18 and over
Thrombocytosis, 40 and over	Lung	Consider an urgent chest X-ray (to be done within 2 weeks) [1.1.3]
Thrombocytosis with visible haematuria or vaginal discharge (unexplained) in women 55 and over	Endometrial	Consider a direct access ultrasound scan [1.5.12]
White cell count raised on a blood test with unexplained non-visible haematuria, 60 and over	Bladder	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.6.4]

Dermoscopy findings

Investigation findings and specific features	Possible cancer	Recommendation
Dermoscopy suggests melanoma of the skin	Melanoma	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.7.2]

Digital rectal examination findings

Examination findings and specific features	Possible cancer	Recommendation
Prostate feels malignant on digital rectal examination	Prostate	Refer men using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.6.1]

Faecal tests

Investigation findings and specific features	Possible cancer	Recommendation
Occult blood in faeces	Colorectal	Refer adults using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.3.1]

Imaging tests

Investigation findings and specific features	Possible cancer	Recommendation
Chest X-ray suggests lung cancer	Lung	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.1.1]
Chest X-ray suggests mesothelioma	Mesothelioma	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.1.4]
Ultrasound suggests ovarian cancer	Ovarian	Make an urgent referral for further investigation [1.5.8] These recommendations apply to women aged 18 and over
Ultrasound normal with CA125 of 35 IU/ml or greater	Ovarian	Assess carefully for other clinical causes of her symptoms and investigate if appropriate If no other clinical cause is apparent, advise her to return to her GP if her symptoms become more frequent and/or persistent [1.5.9] These recommendations apply to women aged 18 and over

Investigation findings and specific features	Possible cancer	Recommendation
Ultrasoundsuggests soft tissue sarcoma or is uncertain and clinical concern persists in adults	Soft tissue sarcoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.11.5] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
X-ray suggests the possibility of bone sarcoma in adults	Bone sarcoma	Consider a suspected cancer pathway referral (for an appointment within 2 weeks) [1.11.1] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements

Jaundice

Investigation findings and specific features	Possible cancer	Recommendation
Jaundice, 40 and over	Pancreatic	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.2.4]

Urine test findings

Investigation findings and specific features	Possible cancer	Recommendation
Bence–Jones protein urine results suggest myeloma	Myeloma	Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) [1.10.7]

Symptoms in children and young people

Abdominal symptoms

Symptom and specific features	Possible cancer	Recommendation
Hepatosplenomegaly (unexplained) in children and young people	Leukaemia	Refer for immediate specialist assessment [1.10.2]
Abdominal mass (palpable) or enlarged abdominal organ (unexplained) in children	Neuroblastoma or Wilms' tumour	Consider very urgent referral (for an appointment within 48 hours) for specialist assessment [1.12.1] [1.12.3]
Splenomegaly (unexplained) in children and young people	Non-Hodgkin's lymphoma	Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment. When considering referral, take into account any associated symptoms, particularly fever, night sweats, shortness of breath, pruritus or weight loss [1.10.9] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements

Bleeding, bruising or rashes

Symptom and specific features	Possible cancer	Recommendation
Petechiae (unexplained) in children and young people	Leukaemia	Refer for immediate specialist assessment [1.10.2]
Bleeding or bruising (unexplained) in children and young people	Leukaemia	Offer a very urgent full blood count (within 48 hours) [1.10.3]

Lumps or masses

Symptom and specific features	Possible cancer	Recommendation
Lymphadenopathy (unexplained) in children and young people	Non-Hodgkin's lymphoma or Hodgkin's lymphoma	Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment. When considering referral, take into account any associated symptoms, particularly fever, night sweats, shortness of breath, pruritus or weight loss [1.10.9] [1.10.11] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Lymphadenopathy (generalised) in children and young people	Leukaemia	Offer a very urgent full blood count (within 48 hours) [1.10.3]
Lump (unexplained) that is increasing in size in children and young people	Soft tissue sarcoma	Consider a very urgent direct access ultrasound scan (to be done within 48 hours) [1.11.6] See the section on primary care investigations for more information on ultrasound scans Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements

See also the section on abdominal symptoms for abdominal mass or unexplained enlarged abdominal organ, splenomegaly and hepatosplenomegaly.

Neurological symptoms

Symptom and specific features	Possible cancer	Recommendation
Newly abnormal cerebellar or other central neurological function in children and young people	Brain or central nervous system cancer	Consider a very urgent referral (for an appointment within 48 hours) [1.9.2]

Respiratory symptoms

Symptom and specific features	Possible cancer	Recommendation
Shortness of breath with lymphadenopathy in children and young people	Non-Hodgkin's lymphoma or Hodgkin's lymphoma	Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment. When considering referral, take into account any associated symptoms [1.10.9] [1.10.11] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Shortness of breath with splenomegaly (unexplained) in children and young people	Non-Hodgkin's lymphoma	Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment. When considering referral, take into account any associated symptoms [1.10.9] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements

Skeletal symptoms

Symptom and specific features	Possible cancer	Recommendation
Bone pain (persistent or unexplained) in children and young people	Leukaemia	Offer a very urgent full blood count (within 48 hours) [1.10.3]

Symptom and specific features	Possible cancer	Recommendation
Bone pain (unexplained) in children and young people	Bone sarcoma	Consider a very urgent direct access X-ray (to be done within 48 hours) [1.11.3] See the section on primary care investigations for more information on X-rays
Bone swelling (unexplained) in children and young people	Bone sarcoma	Consider a very urgent direct access X-ray (to be done within 48 hours) [1.11.3] See the section on primary care investigations for more information on X-rays

Skin or surface symptoms

Symptom and specific features	Possible cancer	Recommendation
Petechiae (unexplained) in children and young people	Leukaemia	Refer for immediate specialist assessment [1.10.2]
Bruising (unexplained) in children and young people	Leukaemia	Offer a very urgent full blood count (within 48 hours) [1.10.3]
Pallor in children and young people	Leukaemia	Offer a very urgent full blood count (within 48 hours) [1.10.3]

Urological symptoms

Symptom and specific features	Possible cancer	Recommendation
Haematuria (visible and unexplained) in children	Wilms' tumour	Consider very urgent referral (for an appointment within 48 hours) for specialist assessment [1.12.3]

Non-specific features of cancer

Symptom and specific features	Possible cancer	Recommendation
Fatigue (persistent) in children and young people	Leukaemia	Offer a very urgent full blood count (within 48 hours) [1.10.3]
Fever with lymphadenopathy (unexplained) in children and young people	Non-Hodgkin's lymphoma or Hodgkin's lymphoma	Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment. When considering referral, take into account any associated symptoms [1.10.9] [1.10.11] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Fever with splenomegaly (unexplained) in children and young people	Non-Hodgkin's lymphoma	Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment. When considering referral, take into account any associated symptoms [1.10.9] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Fever (unexplained) in children and young people	Leukaemia	Offer a very urgent full blood count (within 48 hours) [1.10.3]
Infection (unexplained and persistent) in children and young people	Leukaemia	Offer a very urgent full blood count (within 48 hours) [1.10.3]

Symptom and specific features	Possible cancer	Recommendation
Lymphadenopathy (unexplained) in children and young people	Non-Hodgkin's lymphoma or Hodgkin's lymphoma	Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment. When considering referral, take into account any associated symptoms, particularly fever, night sweats, shortness of breath, pruritus or weight loss [1.10.9] [1.10.11] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Lymphadenopathy (generalised) in children and young people	Leukaemia	Offer a very urgent full blood count (within 48 hours) [1.10.3]
Night sweats with lymphadenopathy (unexplained) in children and young people	Non-Hodgkin's lymphoma or Hodgkin's lymphoma	Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment. When considering referral, take into account any associated symptoms [1.10.9] [1.10.11] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Night sweats with splenomegaly (unexplained) in children and young people	Non-Hodgkin's lymphoma	Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment. When considering referral, take into account any associated symptoms [1.10.9] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements

Symptom and specific features	Possible cancer	Recommendation
Pruritus with lymphadenopathy (unexplained) in children and young people	Non-Hodgkin's lymphoma or Hodgkin's lymphoma	Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment. When considering referral, take into account any associated symptoms [1.10.9] [1.10.11] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Pruritus with splenomegaly (unexplained) in children and young people	Non-Hodgkin's lymphoma	Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment. When considering referral, take into account any associated symptoms [1.10.9] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
Weight loss with lymphadenopathy (unexplained) in children and young people	Non-Hodgkin's lymphoma or Hodgkin's lymphoma	Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment in children and young people. When considering referral, take into account any associated symptoms [1.10.9] [1.10.11] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements

Symptom and specific features	Possible cancer	Recommendation
Weight loss with splenomegaly (unexplained) in children and young people	Non-Hodgkin's lymphoma	Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment. When considering referral, take into account any associated symptoms [1.10.9] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements

Ocular examination

Examination findings and specific features	Possible cancer	Recommendation
Absent red reflex in children	Retinoblastoma	Consider urgent referral (for an appointment within 2 weeks) for ophthalmological assessment [1.12.2]

Parental concern

Symptom and specific features	Possible cancer	Recommendation
Parental or carer insight, concern or anxiety about the child's or young person's symptoms (persistent)	Childhood cancer	Take into account the insight and knowledge of parents and carers when considering making a referral for suspected cancer in a child or young person Consider referral for children if their parent or carer has persistent concern or anxiety about the child's symptoms, even if the symptoms are most likely to have a benign cause [1.13.1]

Primary care investigations

Symptom and specific features	Possible cancer	Recommendation
Ultrasound scan suggests soft tissue sarcoma or is uncertain and clinical concern persists in children and young people	Soft tissue sarcoma	Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment [1.11.7] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements
X-ray suggests the possibility of bone sarcoma in children and young people	Bone sarcoma	Consider a very urgent referral (for an appointment within 48 hours) for specialist assessment [1.11.2] Separate recommendations have been made for adults and for children and young people to reflect that there are different referral pathways. In practice young people (aged 16 to 24) may be referred using either pathway depending on their age and local arrangements

Terms used in this guideline

Children

From birth to 15 years.

Children and young people

From birth to 24 years.

Consistent with

The finding has characteristics that could be caused by many things, including cancer.

Direct access

When a test is done and primary care retain clinical responsibility throughout, including acting on the result.

Immediate

An acute admission or referral occurring within a few hours, or even more quickly if necessary.

Non-urgent

The timescale generally used for a referral or investigation that is not considered very urgent or urgent.

Persistent

The continuation of specified symptoms and/or signs beyond a period that would normally be associated with self-limiting problems. The precise period will vary depending on the severity of symptoms and associated features, as assessed by the health professional.

Raises the suspicion of

A mass or lesion that has an appearance or a feel that makes the healthcare professional believe cancer is a significant possibility.

Safety netting

The active monitoring in primary care of people who have presented with symptoms. It has 2 separate aspects:

- timely review and action after investigations
- active monitoring of symptoms in people at low risk (but not no risk) of having cancer to see if their risk of cancer changes.

Suspected cancer pathway referral

The patient is seen within the national target for cancer referrals (2 weeks at the time of publication of this guideline).

Unexplained

Symptoms or signs that have not led to a diagnosis being made by the healthcare professional in primary care after initial assessment (including history, examination and any primary care investigations).

Urgent

To happen or be done before 2 weeks. An urgent referral means that the woman is referred to a gynaecological cancer service within the national target in England and Wales for referral for suspected cancer, which is currently 2 weeks.

Very urgent

To happen within 48 hours.

Young people

Aged 16 to 24 years.

Recommendations for research

The guideline committee has made the following recommendations for research.

Key recommendations for research

1 Age thresholds in cancer

Longitudinal studies should be carried out to identify and quantify factors in adults that are associated with development of specific cancers at a younger age than the norm. They should be designed to inform age thresholds in clinical guidance. The primary outcome should be likelihood ratios and positive predictive values for cancer occurring in younger age groups.

2 Primary care testing

Diagnostic accuracy studies of tests accessible to primary care should be carried out for a given cancer in symptomatic people. Priority areas for research should include tests for people with cough, non-visible haematuria, suspected prostate cancer, suspected pancreatic cancer, suspected cancer in childhood and young people and other suspected rare cancers. Outcomes of interest are the performance characteristics of the test, particularly sensitivity, specificity and positive and negative predictive values.

3 Cancers insufficiently researched in primary care

Observational studies of symptomatic primary care patients should be used to estimate the positive predictive value of different symptoms for specific cancers. Priority areas for research are those where the evidence base is currently insufficient and should include prostate cancer, pancreatic cancer, cancer in childhood and young people and other rare cancers. Outcomes of interest are positive predictive values and likelihood ratios for cancer.

4 Patient experience

Qualitative studies are needed to assess the key issues in patient experience and patient information needs in the cancer diagnostic pathway, particularly in the interval between first presentation to primary care and first appointment in secondary care. Outcomes of interest are patient satisfaction, quality of life and patient perception of the quality of care and information.

5 Prostate-specific antigen testing

What is the diagnostic accuracy of using age-adjusted and fixed prostate-specific antigen thresholds for people with symptoms of prostate cancer, including those at high risk of developing prostate cancer (such as those with an African family background or a family history of prostate cancer)?

For a short explanation of why the committee made the recommendation for research see the rationale section on prostate-specific antigen testing for prostate cancer.

Full details of the evidence and the committee's discussion are in evidence review A: PSA testing for prostate cancer.

Rationale and impact

This section briefly explains why the committee made the recommendation and how it might affect practice.

Prostate-specific antigen testing for prostate cancer

Recommendation 1.6.3

Why the committee made the recommendation

The evidence on the diagnostic accuracy of fixed and age-specific prostate-specific antigen (PSA) thresholds was very uncertain because all of the studies were based on a population that had already been referred to secondary care. The 2019 guideline recommended referral if PSA levels were above the age-specific reference range. The committee agreed that referral should be considered based on PSA thresholds, but did not make a stronger recommendation because of the uncertainty in the evidence and the likely low positive predictive value of the PSA test for prevalence estimates based on UK population data. The committee noted that many prostate cancers are slow growing and might never impact a person's life expectancy. Some people might choose not to be referred to secondary care to avoid invasive investigations and treatment that might not benefit them. Therefore, the committee agreed that a patient-centred approach to referral is important, and recommended that the person's preferences and any comorbidities should be taken into account.

The committee agreed that more research is needed in this area to better understand the most appropriate thresholds that should prompt referral to secondary care for each age group. The committee noted that ethnicity and family history are important factors that affect the risk of prostate cancer. Therefore, they recommended that the data from research be stratified by these factors to determine whether different PSA levels should prompt referral in these groups. Research in this area may also help to address health inequalities in prostate cancer diagnosis and outcomes in the UK.

There was no strong evidence to differentiate between using age-specific or fixed PSA thresholds. The committee also noted that no cost-effectiveness evidence comparing age-specific thresholds with fixed thresholds was identified. However, because PSA levels increase naturally with age, the committee agreed a lower fixed PSA threshold would detect more cases of prostate cancer but also lead to unnecessary biopsies and overtreatment in some age groups. This would also be likely to

result in more referrals to secondary care and have a significant impact on NHS resources. The committee therefore recommended the use of age-specific thresholds, which are already established in current practice and were recommended in the previous version of the guideline. Because of regional variations in practice (particularly in the 50 to 69 age range), the committee decided to define the age-specific PSA thresholds. The committee agreed that the thresholds used in the reviewed studies on people with symptoms of possible prostate cancer should be used in the absence of evidence to support alternative values, because these studies were most applicable to the population that the recommendation applies to. No evidence was available specifically for people under 40 or over 79, and so the committee recommended that clinical judgement is used when deciding whether to refer people in these groups to secondary care.

How the recommendation might affect practice

Referral based on age-specific PSA thresholds is already recommended, so practice should not change significantly. Also, clarifying the age-specific thresholds will help standardise care. Taking into account patient preferences and comorbidities should also lead to a more patient-centred approach to referral.

Return to recommendation

Context

Cancer has an enormous impact, both in terms of the number of people affected by it and the individual impact it has on people with cancer and those close to them. More than 300,000 new cancers (excluding skin cancers) are diagnosed annually in the UK, across over 200 different cancer types. Each of these cancer types has different presenting features, though they sometimes overlap. Approximately one-third of the population will develop a cancer in their lifetime. There is considerable variation in referral and testing for possible cancer, which cannot be fully explained by variation in the population.

The identification of people with possible cancer usually happens in primary care, because most people first present to a primary care clinician. Therefore, evidence from primary care should inform the identification process and was used as the basis for this guideline.

The recommendations were developed using a 'risk threshold', whereby if the risk of symptoms being caused by cancer is above a certain level, then action (investigation or referral) is warranted. The positive predictive value (PPV) was used to determine the threshold. In the previous guideline, a disparate range of percentage risks of cancer was used to form the recommendations. Few corresponded with a PPV of lower than 5%. The guideline development group (GDG) felt that, in order to improve diagnosis of cancer, a PPV threshold lower than 5% was preferable. Taking into account the financial and clinical costs of broadening the recommendations, the GDG agreed to use a 3% PPV threshold value to underpin the recommendations for suspected cancer pathway referrals and urgent direct access investigations, such as brain scanning or endoscopy. Certain exceptions to a 3% PPV threshold were agreed. Recommendations were made for children and young people at below the 3% PPV threshold, although no explicit threshold value was set. The threshold was not applied to recommendations relating to tests routinely available in primary care (including blood tests such as prostate-specific antigen and imaging such as chest X-ray), primary care tests that could be used in place of specialist referral, non-urgent direct access tests and routine referrals for specialist opinion. Further information about the methods used to underpin the recommendations can be found in the full guideline.

It is well recognised that some risk factors increase the chance of a person developing cancer in the future, for example, increasing age and a family history of cancer. However, risk factors do not affect the way in which cancer presents. Of the risk factors that were reported in the evidence, only smoking (in lung cancer) and age were found to significantly influence the chance of symptoms being predictive of cancer. Therefore, these are included in the recommendations where relevant. For all other risk factors, the recommendations would be the same for people with possible

symptoms of cancer, irrespective of whether they had a risk factor. However, an exception was made to include asbestos exposure in the recommendations because of the high relative risk of mesothelioma in people who have been exposed to asbestos.

Finding more information and committee details

You can see everything NICE says on this topic in the NICE Pathways on suspected cancer recognition and referral and lung cancer.

To find NICE guidance on related topics, including guidance in development, see our topic page on cancer.

For full details of the evidence and the guideline committee's discussions, see the full guideline. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting NICE guidelines into practice, see resources to help you put guidance into practice.

Update information

December 2021: We reviewed the evidence on fixed and age-adjusted thresholds for PSA testing and updated recommendation 1.6.3.

January 2021: We amended recommendation 1.3.4 to include the full list of criteria for faecal testing. Faecal testing should also be offered to people without rectal bleeding aged 50 or over with unexplained abdominal pain or weight loss, or to adults under 60 with changes in bowel habit or iron-deficiency anaemia. The tables of symptoms and findings have been updated to match these changes.

September 2020: Recommendation 1.3.4 was amended to clarify when to offer faecal testing for colorectal cancer to adults without rectal bleeding. The tables on abdominal and pelvic pain, change in bowel habit and primary care investigations were updated in line with this. The wording in some recommendations was edited to incorporate text previously in footnotes.

July 2017: Recommendation 1.3.4 was replaced by NICE diagnostics guidance on quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care. Recommendation 1.3.1 was amended to remove a link to recommendation 1.3.4. In December 2017, the wording of 1.3.4 was clarified, and the tables on abdominal and pelvic pain, change in bowel habit and primary care investigations updated in line with this.

June 2016: Recommendations 1.3.1 and 1.3.2 have been changed to say 'adults' instead of 'people' to more accurately reflect the populations they cover.

June 2015: This guideline updates and replaces NICE guideline CG27 (published June 2005).

Recommendations are marked as [2021], [2020], [2015], [2011], [2011, amended 2020] or [2005]:

- [2021] indicated that the evidence has been reviewed and the recommendation has been updated in 2021.
- [2020] indicates that the evidence has been reviewed and the recommendation has been added or updated in 2020.
- [2011, amended 2020] indicates that the wording has been changed but the evidence has not been reviewed since 2020.

- [2015], [2005] or [2011] indicates the date that the evidence was last reviewed.

Minor changes since publication

October 2021: In recommendation 1.12.2 we added a cross-reference to NICE's guideline on suspected neurological conditions for advice for children who have new-onset squint with an absent red reflex. See the surveillance report for more information. We also added a link to NICE's guideline on babies, children and young people's experience of healthcare in the sections on childhood cancers and symptoms in children and young people.

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Accreditation

Southern Health and Social Care Trust

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier: [redacted]

Date of Incident/Event: 28 July 2020

HSCB Unique Case Identifier: S[redacted]

Service User Details: (*complete where relevant*)
D.O.B: [redacted] Gender: M Age: [redacted]

Responsible Lead Officer: Dr Dermot Hughes

Designation: Former Medical Director Western Health and Social Care Trust. Former Medical Director of the Northern Ireland Cancer Network (NICAN)

Report Author: The Review Team

Date report signed off: 26 February 2021

Date submitted to HSCB: 1 March 2021

[redacted]

1.0 EXECUTIVE SUMMARY

XX was an Personal Information old gentleman when he first presented with haematuria to Emergency Department (ED) in Craigavon Area Hospital (CAH) on 12 December 2018. He complained of low back pain. There was no evidence of urinary tract infection. He was referred to urology services and was reviewed by Dr 1 in January 2019.

2.0 THE REVIEW TEAM

Dr Dermot Hughes – External Independent Chair: Former Medical Director Western Health and Social Care Trust. Former Medical Director of the Northern Ireland Cancer Network (NICAN).
Mr Hugh Gilbert - Expert External Clinical Advisor from the British Association of Urological Surgeons BAUS
Mrs Fiona Reddick – Head of Cancer Services (SHSCT)
Ms Patricia Thompson – Clinical Nurse Specialist (Formally from SET recently SHSCT)
Mrs Patricia Kingsnorth – Acting Acute Clinical and Social Care Governance Coordinator (SHSCT)

3.0 SAI REVIEW TERMS OF REFERENCE

The aims and objectives of this review are to:

- To carry out a systematic multidisciplinary review of the process used in the diagnosis, multidisciplinary team decision making and subsequent follow up and treatment provided for each patient identified, using a Root Cause Analysis (RCA) Methodology.
- To review individually the quality of treatment and care provided to each patient identified and consider any factors that may have adversely influenced or contributed to subsequent clinical outcomes.
- To engage with patients / families to ensure where possible questions presented to the review team or concerns are addressed within the review.
- To develop recommendations to establish what lessons are to be learned and how our systems can be strengthened regarding the delivery of safe, high quality care.
- Examine any areas of good practice and opportunities for sharing learning from the incidents.
- To share the report with the Director of Acute Services/ Medical Director of SHSCT/ HSCB/Patient/ Staff involved.

4.0 REVIEW METHODOLOGY

Review of Medical Notes

Interviews with Staff

Review of the Northern Ireland Electronic Care Record

Irrelevant redacted by the USI

Family Engagement

MDT pathway for Cancer Management

5.0 DESCRIPTION OF INCIDENT/CASE

XX, an Personal Information-old gentleman, presented with haematuria to the Emergency Department (ED) at Craigavon Area Hospital (CAH) on Personal Information redacted by USI. He complained of low back pain There was no evidence of urinary tract infection. A digital rectal examination (DRE) showed a smooth prostate gland query right side bigger than left but no rectal bleeding was seen. He was referred as an outpatient to the urology services as a red flag referral. A PSA blood test was not requested. The patient's family contacted Dr.1's secretary and requested a private appointment. However, Dr.1 (Consultant Urologist) arranged a CT scan of chest and CT urogram which were performed on Personal information redacted by USI prior to an expedited review at urology outpatients as urgent.
The CT scan showed a large right kidney tumour measuring 15cms in diameter with possible vein involvement. There was no evidence of metastatic disease. His case was discussed on 17 January 2019 at the multidisciplinary team meeting (MDM) when it was recommended that XX was reviewed by Dr.1 in outpatients to discuss management options.

XX was reviewed by Dr.1 on Personal Information redacted by USI and the findings of the scan were explained to him. A MRI venogram, to assess if any extensive involvement of the major vessels, and a DMSA scan, to quantify the function of the left kidney, were both requested. At the same time an echocardiogram and an anaesthetic referral were arranged to assess the risk factors for surgery.

On Personal information redacted by USI, XX attended for a DMSA which showed that "the function left kidney 63%; right kidney 37% function. The MRI venogram confirmed a tumour in the right renal vein but this did not extend into the inferior vena cava.

Personal information redacted by USI XX attended for the anaesthetic review with Dr.2 (Consultant Intensivist) and a stay on the High Dependency Unit following surgery was recommended. XX was noted to be keen for surgery.

Personal information redacted by USI XX was discussed at the MDM when the imaging results were noted. The pre-operative assessment was also discussed and noted a high risk of mortality and morbidity in the post-operative period. It was planned for Dr.1 to review XX, with his family, to ensure that surgery was in his best interest.

Personal information redacted by USI XX, accompanied by his Personal Information redacted by USI, was reviewed by Dr.1 when the risks and benefits of the surgery were explained: XX opted for surgical intervention. Precise pre-operative instructions and arrangements for bridging anti-coagulation were given to XX.

Personal information redacted by USI XX was admitted for an elective radical nephrectomy. The

Irrelevant redacted by the USI

5.0 DESCRIPTION OF INCIDENT/CASE

procedure was undertaken as planned and he was transferred to the intensive care unit (ICU) as he needed blood pressure support. He was, that day, later transferred to the ward. He developed a bacteraemia (infection) which was managed with antibiotic therapy following advice from the microbiology team.

Personal Information redacted by USI XX's case and progress were presented at MDM. The recommendation was for a CT scan 3 months post operatively. He was discharged home on 17 March 2019.

Personal information redacted by USI Dr.1 reviewed XX in outpatient and noted him to be well. A plan for CT scan chest abdomen and pelvis was arranged for June 2019 with a clinic review planned at the urology clinic in July 2019. A post-operative anaemia was treated.

Personal information redacted by USI a CT scan of chest abdomen and pelvis was performed. There was no change in comparison from previous scans.

Personal information redacted by USI Dr 3 (Consultant Cardiologist) reviewed XX at a cardiology appointment following a referral from his GP. XX was noted to have increased fatigue and dyspnoea. He was also noted to have anaemia and deranged renal function. He was admitted for observation and investigation. Dr.1 was advised of the admission. XX was discharged on Personal information redacted by USI Subsequently, Dr.1 telephoned XX to inform him that a CT scan of the chest, abdomen and pelvis would be arranged in December at South Tyrone Hospital. Review was planned for January 2020.

On Personal information redacted by USI a CT scan of chest abdomen and pelvis was performed the results showed a possible sclerotic metastasis in the L1 vertebral body. The scan report was available on 11 January 2020.

On 28 July 2020 following a telephone conversation between Dr.4 (Consultant Urologist) and XX's daughter, a letter was sent to XX to advise of the CT result and to apologise for the delay. Dr.4 advised of a possible abnormality on the CT scan that required further investigation with a bone scan.

The bone scan Personal information redacted by USI confirmed new sclerotic abnormalities in the spine, pelvis, the ribs and the left femur. His PSA was noted to be 138 ng/L. On this basis metastatic prostate cancer was confirmed.

Personal information redacted by USI XX, accompanied by his daughters, was reviewed by Dr.4 in outpatients and his treatment options were discussed. Androgen deprivation therapy was commenced and a referral to the Oncology Service was made.

Dr.4 noted in his clinic letter that the scan performed in December 2019 had not been followed up and that there had been no communication with XX about the results.

A review was planned for November 2020.

6.0 FINDINGS

- XX case was appropriately discussed at the multidisciplinary meetings pre- and post-surgery.

- A urology review was planned for July 2019 following the CT scan report in June, but this did not happen. The review team note that XX appeared to be lost to follow up.

- In a letter to XX dated 30 November 2019, Dr.1 advised that he was arranging a further CT scan to be performed in December and to reviewing him at the urology clinic in January 2020.

- The review team note that the scan was performed on [redacted] reported by the radiology team on 4 January 2020, but no follow up occurred.

- The review team have identified that the MDM was not quorate as no oncologist present for the meetings.

- XX was not referred to a Cancer Nurse Specialist or Keyworker to support him with his diagnosis. Nor was any contact details given to him. The Northern Ireland Cancer Services recommendations for Peer Review include that "all newly diagnosed patients have a Key Worker appointed, a Holistic Needs Assessment conducted, adequate communication and information, advice and support given, and all recorded in a Permanent Record of Patient Management which will be shared and filed in a timely manner"(1). This did not happen and was detrimental to the patient's experience.

- The review team are of the opinion that a specialist nurse would also have been a failsafe for identifying the delayed scan report and bringing it back to the MDM sooner.

  The review team are mindful that the family have concerns that when XX presented in ED with urinary symptoms a PSA was not undertaken. It would appear from the electronic records that a PSA test was never undertaken until August 2020.

- The CT scan, performed in January 2020, was not actioned until July 2020. Fortunately, no significant metastasis related event occurred in this 6 month period so will probably have no long-term effect on the disease's progress.

7.0 CONCLUSIONS

The management of XX's renal tumour was exemplary. The abnormal findings on the post-operative review scan should have been noted and acted upon. It would be unusual for a renal cell carcinoma to produce a sclerotic metastatic bone deposit and other options should have been considered.

8.0 LESSONS LEARNED

- An acknowledgement mechanism for email alerts to adverse radiological reports should have been in place.
- The MDM tracking capacity was insufficient to provide an additional safety net for patient follow up.
- Absence of a Urology Cancer Nurse Specialist is an additional risk for successful patient follow up.

9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation 1

All patients receiving care from the SHSCT Urology Cancer Services should be appropriately supported and informed about their cancer care. This should meet the standards set out in Regional and National Guidance and meet the expectation of Cancer Peer Review. This must be supported by a Urology Cancer Nurse Specialist at an early point in their surveillance journey**.**

Recommendation 2

The Trust must ensure that patients are discussed appropriately at MDM and by the appropriate professionals. In this case it would be essential to improve radiological resource.

Recommendation 3

The Southern Health and Social Care Trust must ensure that MDM meetings are resourced to provide appropriate tracking of patients and to confirm agreed recommendations / actions are completed. This should be supported by a clinical nurse specialist, a radiology alert system and the consultant.

Recommendation 4

All patients should receive cancer care based on accepted best care Guidelines (NICAN Regional Guidance, NICE Guidance, Improving Outcome Guidance). This includes onward referral for appropriate advice

9.0 RECOMMENDATIONS AND ACTION PLANNING

References:

1. **Peer Review Self-Assessment Report for NICAN (2017).**

10.0 DISTRIBUTION LIST

Mr Shane Devlin – Chief Executive SHSCT

Mrs Melanie McClements Director of Acute Services SHSCT

Dr Maria O'Kane – Medical Director SHSCT

Mrs Heather Trouton – Executive Director of Nursing Midwifery and AHPs

HSCB

PHA

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

(This checklist should be completed in full and submitted to the HSCB along with the completed SAI Review Report for all levels of SAI reviews)

Reporting Organisation SAI Ref Number:	Personal information redacted by USI	**HSCB Ref Number:**	Personal information

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, a number of service users or if the SAI relates **only** to a HSC Child Death notification *(SAI criterion 4.2.2)* **Please select as appropriate (✓)**	**Single Service User**	1	**Multiple Service Users***		**HSC Child Death Notification only**		
	Comment: ****If multiple service users involved please indicate the number involved***						
2) Was the Service User[1] / Family / Carer informed the incident was being investigated as a SAI? **Please select as appropriate (✓)**	**YES**	x	**NO**				
	If **YES**, insert **date informed**: **26 October 2020**						
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being investigated as a SAI						
	a) No contact or Next of Kin details or Unable to contact						
	b) Not applicable as this SAI is not 'patient/service user' related						
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user						
	d) Case involved suspected or actual abuse by family						
	e) Case identified as a result of review exercise						
	f) Case is environmental or infrastructure related with no harm to patient/service user						
	g) Other rationale						
	If you selected c), d), e), f) or g) above please provide further details:						
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**							
Content with rationale?	**YES**		**NO**				

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)

3) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	x
	If **YES**,			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			x
	c) Report not shared but contents discussed			

[1]*Service User or their nominated representative*

This checklist should be completed in line with the HSCB Procedure for the reporting and follow up of SAIs October 2013 and the HSC Guidance for staff on engagement/communication with Service Users[1] / Families/Carers following a SAI

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)*		
Continued overleaf	**(*if you select this option please also complete 'l' below*)**	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2

INFORMING THE CORONER'S OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*				
1) Was there a Statutory Duty to notify the Coroner at the time of death? **Please select as appropriate (✓)**	**YES**		**NO**	**x**
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) Following or during the review of the SAI was there a Statutory Duty to notify the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	**x**
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
3) If you have selected 'YES' to any of the above **'1' or '2'** has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	**1.3.2021**

[1] *Service User or their nominated representative*

This checklist should be completed in line with the HSCB Procedure for the reporting and follow up of SAIs October 2013 and the HSC Guidance for staff on engagement/communication with Service Users[1] / Families/Carers following a SAI

Health and Social Care Board

Procedure for the Reporting and Follow up of Serious Adverse Incidents

November 2016
Version 1.1

CONTENTS

SECTION TWO - APPENDICES

SECTION THREE - ADDENDUM

FOREWORD

Commissioners and Providers of health and social care want to ensure that when a serious event or incident occurs, there is a systematic process in place for safeguarding services users, staff, and members of the public, as well as property, resources and reputation.

One of the building blocks for doing this is a clear, regionally agreed approach to the reporting, management, follow-up and learning from serious adverse incidents (SAIs). Working in conjunction with other Health and Social Care (HSC) organisations, this procedure was developed to provide a system-wide perspective on serious incidents occurring within the HSC and Special Agencies and also takes account of the independent sector where it provides services on behalf of the HSC.

The procedure seeks to provide a consistent approach to:

- what constitutes a serious adverse incident;
- clarifying the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning;
- fulfilling statutory and regulatory requirements;
- tools and resources that support good practice.

Our aim is to work toward clearer, consistent governance arrangements for reporting and learning from the most serious incidents; supporting preventative measures and reducing the risk of serious harm to service users.

The implementation of this procedure will support governance at a local level within individual organisations and will also improve existing regional governance and risk management arrangements by continuing to facilitate openness, trust, continuous learning and ultimately service improvement.

This procedure will remain under continuous review.

Valerie Watts
Chief Executive

SECTION ONE - PROCEDURE

1.0 BACKGROUND

Circular HSS (PPM) 06/04 introduced interim guidance on the reporting and follow-up on serious adverse incidents (SAIs). Its purpose was to provide guidance for HPSS organisations and special agencies on the reporting and management of SAIs and near misses.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hss(ppm)06-04.pdf

Circular HSS (PPM) 05/05 provided an update on safety issues; to underline the need for HPSS organisations to report SAIs and near misses to the DHSSPS in line with Circular HSS (PPM) 06/04.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hssppm05-05.pdf

Circular HSS (PPM) 02/2006 drew attention to certain aspects of the reporting of SAIs which needed to be managed more effectively. It notified respective organisations of changes in the way SAIs should be reported in the future and provided a revised report pro forma. It also clarified the processes DHSSPS had put in place to consider SAIs notified to it, outlining the feedback that would then be made to the wider HPSS.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/qpi_adverse_incidents_circular.pdf

In March 2006, DHSSPS introduced Safety First: A Framework for Sustainable Improvement in the HPSS. The aim of this document was to draw together key themes to promote service user safety in the HPSS. Its purpose was to build on existing systems and good practice so as to bring about a clear and consistent DHSSPS policy and action plan.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/safety_first_-_a_framework_for_sustainable_improvement_on_the_hpss-2.pdf

The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 imposed a 'statutory duty of quality' on HPSS Boards and Trusts. To support this legal responsibility, the Quality Standards for Health and Social Care were issued by DHSSPS in March 2006.

www.health-ni.gov.uk/publications/quality-standards-health-and-social-care-documents

Circular HSC (SQS) 19/2007 advised of refinements to DHSSPS SAI system and of changes which would be put in place from April 2007, to promote learning from SAIs and reduce any unnecessary duplication of paperwork for organisations. It also clarified arrangements for the reporting of breaches of patients waiting in excess of 12 hours in emergency care departments.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hss__sqsd__19-07.pdf

Under the Provisions of Articles 86(2) of the Mental Health (NI) Order 1986, the Regulation & Quality Improvement Authority (RQIA) has a duty to make inquiry into any

case where it appears to the Authority that there may be amongst other things, ill treatment or deficiency in care or treatment. Guidance in relation to reporting requirements under the above Order previously issued in April 2000 was reviewed, updated and re-issued in August 2007. (Note: Functions of the previous Mental Health Commission transferred to RQIA on 1 April 2009).

http://webarchive.proni.gov.uk/20101215075727/http://www.dhsspsni.gov.uk/print/utec_guidance_august_2007.pdf

Circular HSC (SQSD) 22/2009 provided specific guidance on initial changes to the operation of the system of SAI reporting arrangements during 2009/10. The immediate changes were to lead to a reduction in the number of SAIs that were required to be reported to DHSSPS. It also advised organisations that a further circular would be issued giving details about the next stage in the phased implementation which would be put in place to manage the transition from the DHSSPS SAI reporting system, through its cessation and to the establishment of the RAIL system.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2022-09.pdf

Circular HSC (SQSC) 08/2010, issued in April 2010, provided guidance on the transfer of SAI reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency. It also provided guidance on the revised incident reporting roles and responsibilities of HSC Trusts, Family Practitioner Services, the Health & Social Care (HSC) Board and Public Health Agency (PHA), the extended remit of the Regulation & Quality Improvement Authority (RQIA), and the Department.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2008-10.pdf

Circular HSC (SQSD) 10/2010 advises on the operation of an Early Alert System, the arrangements to manage the transfer of Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency and the incident reporting roles and responsibilities of Trusts, family practitioner services, the new regional organisations, the Health & Social Care (HSC) Board and Public Health Agency (PHA), and the extended remit of the Regulation & Quality Improvement Authority (RQIA).

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

In May 2010 the Director of Social Care and Children HSCB issued guidance on 'Untoward Events relating to Children in Need and Looked After Children' to HSC Trusts. This guidance clarified the arrangements for the reporting of events, aligned to delegated statutory functions and Departmental Guidance, which are more appropriately reported to the HSCB Social Care and Children's Directorate.

In 2012 the HSCB issued the 'Protocol for responding to SAIs involving an alleged homicide'. The 2013 revised HSCB 'Protocol for responding to SAIs involving an alleged homicide' is contained in Appendix 14.

Circular HSS (MD) 8/2013 replaces HSS (MD) 06/2006 and advises of a revised Memorandum of Understanding (MOU) when investigating patient or client safety incidents. This revised MOU is designed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required when a serious incident occurs.

www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2013.pdf

DHSSPS Memo dated 17 July 2013 from Chief Medical Officer introduced the HSCB/PHA protocol on the dissemination of guidance/information to the HSC and the assurance arrangements where these are required. The protocol assists the HSCB/PHA in determining what actions would benefit from a regional approach rather than each provider taking action individually.

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/002%20%20HSCB-PHA%20Protocol%20for%20Safety%20Alerts.pdf

Circular HSC (SQSD) 56/16 (21 October 2016) from the Deputy Chief Medical Officer advises of the intention to introduce a Never Events process and that information relating to these events will be captured as part of the Serious Adverse Incident Process. The circular indicates the Never Events process will be based on the adoption of Never Event List with immediate effect.

https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-56-16.pdf

2.0 INTRODUCTION

The purpose of this procedure is to provide guidance to Health and Social Care (HSC) Organisations, and Special Agencies (SA) in relation to the reporting and follow up of Serious Adverse Incidents (SAIs) arising during the course of their business or commissioned service.

The requirement on HSC organisations to routinely report SAIs to the Department of Health (DoH) {formerly known as the DHSSPS} ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the Health and Social Care Board (HSCB) working both jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA).

This process aims to:

- Provide a mechanism to effectively share learning in a meaningful way; with a focus on safety and quality; ultimately leading to service improvement for service users;

- Provide a coherent approach to what constitutes a SAI; to ensure consistency in reporting across the HSC and Special Agencies;

- Clarify the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning arising from SAIs which occur during the course of the business of a HSC organisation / Special Agency or commissioned/funded service;

- Ensure the process works simultaneously with all other statutory and regulatory organisations that may require to be notified of the incident or be involved the review;

- Keep the process for the reporting and review of SAIs under review to ensure it is fit for purpose and minimises unnecessary duplication;

- Recognise the responsibilities of individual organisations and support them in ensuring compliance; by providing a culture of openness and transparency that encourages the reporting of SAIs;

- Ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence;

- Maintain a high quality of information and documentation within a time bound process.

3.0 APPLICATION OF PROCEDURE

3.1 Who does this procedure apply to?

This procedure applies to the reporting and follow up of SAIs arising during the course of the business in Department of Health (DoH) Arm's Length Bodies (ALBs) i.e.

- ***HSC organisations (HSC)***
  - Health and Social Care Board
  - Public Health Agency
  - Business Services Organisation
  - Belfast Health and Social Care Trust
  - Northern Health and Social Care Trust
  - Southern Health and Social Care Trust
  - South Eastern Health and Social Care Trust
  - Western Health and Social Care Trust
  - Northern Ireland Ambulance Service
  - Regulation and Quality Improvement Authority

- ***Special Agencies (SA)***
  - Northern Ireland Blood Transfusion Service
  - Patient Client Council
  - Northern Ireland Medical and Dental Training Agency
  - Northern Ireland Practice and Education Council

The principles for SAI management set out in this procedure are relevant to all the above organisations. Each organisation should therefore ensure that its incident policies are consistent with this guidance while being relevant to its own local arrangements.

3.2 Incidents reported by Family Practitioner Services (FPS)

Adverse incidents occurring within services provided by independent practitioners within: General Medical Services, Pharmacy, Dental or Optometry, are routinely forwarded to the HSCB Integrated Care Directorate in line with the HSCB Adverse Incident Process within the Directorate of Integrated Care (September 2016). On receipt of reported adverse incidents the HSCB Integrated Care Directorate will decide if the incident meets the criteria of a SAI and if so will be the organisation responsible to report the SAI.

3.3 Incidents that occur within the Independent /Community and Voluntary Sectors (ICVS)

SAIs that occur within ICVS, where the service has been commissioned/funded by a HSC organisation must be reported. For example: service users placed/funded by HSC Trusts in independent sector accommodation, including private hospital, nursing or residential care homes, supported housing, day care facilities or availing of HSC funded voluntary/community services. These SAIs must be reported and reviewed by the HSC organisation who has:

- referred the service user (this includes Extra Contractual Referrals) to the ICVS;

or, if this cannot be determined;

- the HSC organisation who holds the contract with the IVCS.

HSC organisations that refer service users to ICVS should ensure all contracts, held with ICVS, include adequate arrangements for the reporting of adverse incidents in order to ensure SAIs are routinely identified.

All relevant events occurring within ICVS which fall within the relevant notification arrangements under legislation should continue to be notified to RQIA.

3.4 Reporting of HSC Interface Incidents

Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. In such instances, it is possible the organisation where the incident may have occurred is not aware of the incident; however the reporting and follow up review may be their responsibility. It will not be until such times as the organisation, where the incident has occurred, is made aware of the incident; that it can be determined if the incident is a SAI.

In order to ensure these incidents are notified to the correct organisation in a timely manner, the organisation where the incident was identified will report to the HSCB using the HSC Interface Incident Notification Form (see Appendix 3). The HSCB Governance Team will upon receipt contact the organisation where the incident has occurred and advise them of the notification in order to ascertain if the incident will be reported as a SAI.

Some of these incidents will subsequently be reported as SAIs and may require other organisations to jointly input into the review. In these instances refer to Appendix 13 – Guidance on Joint Reviews.

3.5 Incidents reported and Investigated/ reviewed by Organisations external to HSC and Special Agencies

The reporting of SAIs to the HSCB will work in conjunction with and in some circumstances inform the reporting requirements of other statutory agencies and external bodies. In that regard, all existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

3.5.1 Memorandum of Understanding (MOU)

In February 2006, the DoH issued circular HSS (MD) 06/2006 − a Memorandum of Understanding − which was developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required into a serious incident.

Circular HSS (MD) 8/2013 replaces the above circular and advises of a revised MOU Investigating patient or client safety incidents which can be found on the Departmental website:

www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2013.pdf

The MOU has been agreed between the DoH, on behalf of the Health and Social Care Service (HSCS), the Police Service of Northern Ireland (PSNI), the Northern Ireland Courts and Tribunals Service (Coroners Service for NI) and the Health and Safety Executive for Northern Ireland (HSENI). It will apply to people receiving care and treatment from HSC in Northern Ireland. The principles and practices promoted in the document apply to other locations, where health and social care is provided e.g. it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSCS.

It sets out the general principles for the HSCS, PSNI, Coroners Service for NI and HSENI to observe when liaising with one another.

The purpose of the MOU is to promote effective communication between the organisations. The MOU will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by the PSNI, Coroners Service for NI or HSENI separately or jointly. This may be the case when an incident has arisen from or involved criminal intent, recklessness and/or gross negligence, or in the context of health and safety, a work-related death.

The MOU is intended to help:

- Identify which organisations should be involved and the lead investigating body.

- Prompt early decisions about the actions and investigations/reviews thought to be necessary by all organisations and a dialogue about the implications of these.

- Provide an understanding of the roles and responsibilities of the other organisations involved in the memorandum before high level decisions are taken.

- Ensure strategic decisions are taken early in the process and prevent unnecessary duplication of effort and resources of all the organisations concerned.

HSC Organisations should note that the MOU does not preclude simultaneous investigations/reviews by the HSC and other organisations e.g. Root Cause Analysis by the HSC when the case is being reviewed by the Coroners Service and/or PSNI/HSENI.

In these situations, the Strategic Communication and Decision Group can be used to clarify any difficulties that may arise; particularly where an external organisation's investigation/review has the potential to impede a SAI review and subsequently delay the dissemination of regional learning.

3.6 Reporting of SAIs to RQIA

RQIA have a statutory obligation to investigate some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA will work in conjunction with the HSCB/PHA with regard to the review of certain categories of SAI. In this regard the following SAIs should be notified to RQIA at the same time of notification to the HSCB:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector (whether statutory or independent) for a service that has been commissioned/funded by a HSC organisation.

  *It is acknowledged these incidents should already have been reported to RQIA as a **'notifiable event'** by the statutory or independent organisation where the incident has occurred (in line with relevant reporting regulations). This notification will alert RQIA that the incident is also being reviewed as a SAI by the HSC organisation who commissioned the service.*

- The HSCB/PHA Designated Review Officer (DRO) will lead and co-ordinate the SAI management, and follow up, with the reporting organisation; however for these SAIs this will be carried out in

conjunction with RQIA professionals. A separate administrative protocol between the HSCB and RQIA can be accessed at Appendix 15.

3.7 Reporting of SAIs to the Safeguarding Board for Northern Ireland

There is a statutory duty for the HSC to notify the Safeguarding Board for Northern Ireland of child deaths where:

- a child has died or been significantly harmed (Regulation 17(2)(a)

AND

- abuse/neglect suspected **or** child or sibling on child protection register **or** child or sibling is/has been looked after Regulation (2)(b) (see Appendix 17)

4.0 DEFINITION AND CRITERIA

4.1 Definition of an Adverse Incident

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'[1] arising during the course of the business of a HSC organisation / Special Agency or commissioned service.

The following criteria will determine whether or not an adverse incident constitutes a SAI.

4.2 SAI criteria

4.2.1 serious injury to, or the unexpected/unexplained death of:

- a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility;

4.2.2 unexpected serious risk to a service user and/or staff member and/or member of the public;

4.2.3 unexpected or significant threat to provide service and/or maintain business continuity;

[1] Source: DoH - How to classify adverse incidents and risk guidance 2006
http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/ph_how_to_classify_adverse__incidents_and_risk_-_guidance.pdf

4.2.4 serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

4.2.5 serious self-harm or serious assault *(including homicide and sexual assaults*)

- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.6 suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.7 serious incidents of public interest or concern relating to:

- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

Note: The HSC Regional Risk Matrix may assist organisations in determining the level of 'seriousness' refer to Appendix 16.

5.0 SAI REVIEWS

SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning from all SAIs reported, it is important the level of review focuses on the complexity of the incident and not solely on the significance of the event.

Whilst most SAIs will be subject to a Level 1 review, for some more complex SAIs, reporting organisations may instigate a Level 2 or 3 review immediately following the incident occurring. The level of review should be noted on the SAI notification form.

The HSC Regional Risk Matrix (refer to Appendix 16) may assist organisations in determining the level of 'seriousness' and subsequently the level of review to be

undertaken. SAIs which meet the criteria in 4.2 above will be reviewed by the reporting organisation using one or more of the following:

5.1 Level 1 Review – Significant Event Audit (SEA)

Most SAI notifications will enter the review process at this level and a SEA will immediately be undertaken to:

- assess what has happened;
- assess why did it happened;
  - what went wrong and what went well;
- assess what has been changed or agree what will change;
- identify local and regional learning.

(refer to Appendix 5 – Guidance Notes for Level 1 – SEA & Learning Summary Report; Appendix 9 – Guidance on Incident Debrief); and Appendix 10 – Level 1 Review - Guidance on review team membership)

The possible outcomes from the review may include:

- closed – no new learning;
- closed – with learning;
- requires Level 2 or 3 review.

A SEA report will be completed **which should be retained by the reporting organisation** (see Appendices 4 and 5).

The reporting organisation will then complete a **SEA Learning Summary Report** (see Appendices 4 and 5 – Sections 1, 3-6), which should be signed off by the relevant professional or operational director and submitted to the HSCB within **8 weeks** of the SAI being notified.

The HSCB will not routinely receive SEA reports unless specifically requested by the DRO. This process assigns reporting organisations the responsibility for Quality Assuring Level 1 SEA Reviews. This will entail engaging directly with relevant staff within their organisation to ensure the robustness of the report and identification of learning prior to submission to the HSCB.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review, the review will move to either a Level 2 or 3 RCA review. In this instance the SEA Learning Report Summary will be forwarded to the HSCB within the timescales outlined above, with additional sections being completed to outline membership and Terms of Reference of the team completing the Level 2 or 3 RCA review and proposed timescales.

5.2 Level 2 – Root Cause Analysis (RCA)

As stated above, some SAIs will enter at Level 2 review following a SEA.

When a Level 2 or 3 review is instigated immediately following notification of a SAI, the reporting organisation will inform the HSCB within 4 weeks, of the Terms of Reference (TOR) and Membership of the Review Team for

consideration by the HSCB/PHA DRO. This will be achieved by submitting sections two and three of the review report to the HSCB. (Refer to Appendix 6 – template for Level 2 and 3 review reports).

The review must be conducted to a high level of detail (see Appendix 7 – template for Level 2 and 3 review reports). The review should include use of appropriate analytical tools and will normally be conducted by a multidisciplinary team (not directly involved in the incident), and chaired by someone independent to the incident but who can be within the same organisation. (Refer to Appendix 9 – Guidance on Incident Debrief); and Appendix 11 – Level 2 Review - Guidance on review team membership).

Level 2 RCA reviews may involve two or more organisations. In these instances, it is important a lead organisation is identified but also that all organisations contribute to, and approve the final review report (Refer to Appendix 13 Guidance on joint reviews/investigations).

On completion of Level 2 reviews, the final report must be submitted to the HSCB within 12 weeks from the date the incident was notified.

5.3 Level 3 – Independent Reviews

Level 3 reviews will be considered for SAIs that:

- are particularly complex involving multiple organisations;
- have a degree of technical complexity that requires independent expert advice;
- are very high profile and attracting a high level of both public and media attention.

In some instances the whole team may be independent to the organisation/s where the incident/s has occurred.

The timescales for reporting Chair and Membership of the review team will be agreed by the HSCB/PHA Designated Review Officer (DRO) at the outset (see Appendix 9 – Guidance on Incident Debrief); and Appendix 12 – Level 3 Review - Guidance on Review Team Membership).

The format for Level 3 review reports will be the same as for Level 2 reviews (see Appendix 7 – guidance notes on template for Level 2 and 3 reviews).

For any SAI which involves an alleged homicide by a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident, the Protocol for Responding to SAIs in the Event of a Homicide, issued in 2012 and revised in 2013 should be followed (see Appendix 14).

5.4 Involvement of Service Users/Family/Carers in Reviews

- Following a SAI it is important, in the spirit of honesty and openness to ensure a consistent approach is afforded to the level of service user / family engagement across the region. When engaging with Service Users/Family/Carers, organisations should refer to addendum 1 – *A Guide for Health and Social Care Staff Engagement/Communication with Service User/Family/Cares following a SAI.*

- In addition a 'Checklist for Engagement/Communication with the Service User/Family/Carers following a SAI' must be completed for each SAI regardless of the review level, and where relevant, if the SAI was also a Never Event (refer to section 12.2).

- The checklist also includes a section to indicate if the reporting organisation had a statutory requirement to report the death to the Coroners office and that this is also communicated to the Family/Carer.

6.0 TIMESCALES

6.1 Notification

Any adverse incident that meets the criteria indicated in section 4.2 should be reported within **72 hours** of the incident being discovered using the SAI Notification Form (see Appendix 1).

6.2 Review Reports

LEVEL 1 – SEA

SEA reports must be completed using the SEA template which will be retained by the reporting organisation (see Appendices 4 and 5). A SEA Learning Summary Report (see Appendices 4 and 5 – Sections 1, 3-6) must be completed and submitted to the HSCB within **8 weeks** of the SAI being reported for all Level 1 SAIs whether learning has been identified or not. The Checklist for Engagement/Communication with Service User/Family/Carer following a SAI' must also accompany the Learning Summary Report.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review, timescales for completion of the RCA will be indicated by Trusts via the Learning Summary Report to the HSCB.

LEVEL 2 – RCA

For those SAIs where a full RCA is instigated immediately, sections 2 and 3 of the RCA Report, outlining TOR and membership of the review team, must be submitted **no later** than **within 4 weeks** of the SAI being notified to the HSCB.

RCA review reports must be fully completed using the RCA report template and submitted together with comprehensive action plans for each recommendation identified to the HSCB **12 weeks** following the date the incident was notified. (see Appendix 6 – Level 2 & 3 RCA Review Reports and Appendix 8 – Guidance on Minimum Standards for Action Plans).

LEVEL 3 – INDEPENDENT REVIEWS

Timescales for completion of Level 3 reviews and comprehensive action plans for each recommendation identified will be agreed between the reporting organisation and the HSCB/PHA DRO as soon as it is determined that the SAI requires a Level 3 review.

Note: Checklist for Engagement/Communication with Service User/Family/Carer following a SAI must accompany all SAI Review/Learning Summary Reports which are included within the report templates.

6.3 Exceptions to Timescales

In most circumstances, all timescales for submission of reports **must be** adhered to. However, it is acknowledged, by exception, there may be occasions where a review is particularly complex, perhaps involving two or more organisations or where other external organisations such as PSNI, HSENI etc.; are involved in the same review. In these instances the reporting organisation must provide the HSCB with regular updates.

6.4 Responding to additional information requests

Once the review / learning summary report has been received, the DRO, with appropriate clinical or other support, will review the report to ensure that the necessary documentation relevant to the level of review is adequate.

If the DRO is not satisfied with the information provided additional information may be requested and must be provided in a timely manner. Requests for additional information should be provided as follows:

- Level 1 review within **2 week**
- Level 2 or 3 review within **6 weeks**

7.0 OTHER INVESTIGATIVE/REVIEW PROCESSES

The reporting of SAIs to the HSCB will work in conjunction with all other HSC investigation/review processes, statutory agencies and external bodies. In that regard, all existing reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

In that regard, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI.

7.1 Complaints in the HSC

Complaints in HSC Standards and Guidelines for Resolution and Learning (The Guidance) outlines how HSC organisations should deal with complaints raised by persons who use/have used, or are waiting to use HSC services. While it is a separate process to the management and follow-up of SAIs, there will be occasions when an SAI has been reported by a HSC organisation, and subsequently a complaint is received relating to the same incident or issues, or alternatively, a complaint may generate the reporting of an SAI.

In these instances, the relevant HSC organisation must be clear as to how the issues of complaint will be investigated. For example, there may be elements of the complaint that will be solely reliant on the outcome of the SAI review and there may be aspects of the complaint which will not be part of the SAI review and can only be investigated under the Complaints Procedure.

It is therefore important that complaints handling staff and staff who deal with SAIs communicate effectively and regularly when a complaint is linked to a SAI review. This will ensure that all aspects of the complaint are responded to effectively, via the most appropriate means and in a timely manner. Fundamental to this, will obviously be the need for the organisation investigating the complaint to communicate effectively with the complainant in respect of how their complaint will be investigated, and when and how they can expect to receive a response from the HSC organisation.

7.2 HSCB Social Care Untoward Events Procedure

The above procedure provides guidance on the reporting of incidents relating to statutory functions under the Children (NI) Order 1995.

If, during the review of an incident reported under the HSCB Untoward Events procedure, it becomes apparent the incident meets the criteria of a SAI, the incident should immediately be notified to the HSCB as a SAI. Board officers within the HSCB will close the Untoward Events incident and the incident will continue to be managed via the SAI process.

7.3 Child and Adult Safeguarding

Any incident involving the suspicion or allegation that a child or adult is at risk of abuse, exploitation or neglect should be investigated under the procedures set down in relation to a child and adult protection.

If during the review of one of these incidents it becomes apparent that the incident meets the criteria for an SAI, the incident will immediately be notified to the HSCB as an SAI.